TB Symptoms Health Screening Checklist
This form only applies to those required to have a chest x-ray or have had an IGRA (Quantiferon) test.

COMP-CA COMP-OR Dental MSMS Nursing Optometry PT-CA PT-OR OTD PA Pharm Podiatry Vet Med

Student/Employee ID @___________________ **Grad. Year: 20 _______**

Name	DOB
Address	Phone:
City/State/Zip	

Date of last PPD ____ PPD Results ______________ MM

Date of IGRA (e.g., Quantiferon/T-Spot) test: _____________________ Results): Negative Positive

Date of Last Chest X-Ray:_____________ Results: Positive for TB Negative for TB

1. Have you ever been told you have active tuberculosis? Yes No

2. Have you ever taken Isoniazid (INH) or Rifampin (RIF)? Yes No

3. Date and duration of medication regime ____ (months)

4. Have you ever had BCG Vaccination? Yes No If yes, when? ________________________________
   (If you have had the BCG vaccination, it is preferred that you obtain an IGRA [e.g., Quantiferon or T-spot test])

5. During the past year have you noticed (circle your answer):

Yes No Unexplained weight loss?
Yes No Decrease in your appetite?
Yes No Cough not associated with cold or flu?
Yes No Increase in AMOUNT of Sputum?
Yes No Change in COLOR of Sputum?
Yes No Change in CONSISTENCY of Sputum?
Yes No Blood Streaked Sputum?
Yes No Night sweats?
Yes No Unexplained low grade fever?
Yes No Unusual tiredness or fatigue?
Yes No Swelling of lymph nodes?
Yes No Have you had contact with a family member or partner who has been diagnosed with tuberculosis?
Yes No Have you or a member of your family been exposed to someone who is immune compromised?

Explain any "Yes" answers above: ____

List any on-going medical problem ____

____ ______________________

Signature of Person Completing this form **Date**

- Plan of care, if indicated: ____

Signature of Reviewer: ____ **Date** ________________

________ No further action needed _________ Chest X-Ray Requested _________ Further Evaluation Needed

Must be reviewed by licensed healthcare provider if any "yes" answers