TB Symptoms Checklist Form

This form only applies to those required to have a chest x-ray of have had an IGRA (Quantiferon) test.

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 (select 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