



# 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.**

College: **COMP-CA COMP-OR Dental MSMS Nursing Optometry PT PA Pharmacy Podiatry Vet Med**

Student/Employee ID # @ \_\_\_\_\_

Grad. Year: 20 \_\_\_\_\_

Name	DOB	Sex: Male Female
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