



Tuberculosis Screening Questionnaire

Name: _____ Age: _____ Date: _____

Student ID#: _____ Date of Birth: _____

Phone #: _____ Email: _____

Please answer the following questions and check appropriate response:

| | YES | NO | Unknown | Year |
|--|-----|----|---------|------|
| Have you EVER had a TB (PPD) skin test? If yes, give date | | | | |
| If yes, was there a reaction? | | | | |
| Have you been exposed to anyone with active tuberculosis? | | | | |
| Have you ever taken Anti-Tuberculin medications? | | | | |
| Were you born / lived / traveled outside the U.S.A.? | | | | |
| Have you had an MMR or chicken pox vaccine in the past 3 months? | | | | |
| Do you currently have an immune compromised illness? | | | | |

Do you currently have any of the following symptoms?

| | YES | NO | Unknown |
|---|-----|----|---------|
| Unexplained fatigue for more than 2 weeks? | | | |
| Weight loss (unintentional)? | | | |
| Unexplained, persistent cough? | | | |
| Cough productive for blood streaked sputum? | | | |
| Unexplained fever? | | | |
| Night sweats? | | | |

I am at least 18 years of age and verify that I have completed the 2-Step Process for Tuberculosis Screening with 2 negative test results within the prior 12 months – the second of which is within 6 months of enrollment in my Health Science program)

Date #1: _____ **Result:** _____

Date #2 _____ **Result:** _____

_____ **Date:** _____

(Signature)