TB SYMPTOM REVIEW

PLEASE CHECK LOCATION AND/OR CATEGORY:

☒ **Student** ☐ **School**_____

NAME: _____ SOCIAL SECURITY #: _____

DEPARTMENT: _____ BIRTHDATE: _____

1. Do you have any medication, food, or other *allergies*? ☐ Yes (please list): _____ ☐ No
2. Have you taken steroids, immunosuppressants or cancer drugs in the last 8 weeks? ☐ Yes ☐ No
3. Have you been exposed recently to anyone with *active* Tuberculosis? ☐ Yes ☐ No
4. Have you ever had a BCG vaccination (given in some foreign countries)? ☐ Yes ☐ No
5. Have you ever taken medications (normally INH) for treatment or prevention of TB? ☐ Yes ☐ No
6. Have you ever had a *positive* TB test? ☐ **YES** Year (if known): _____ ☐ No
   (If "Yes" you should not be given another TB skin test, however, you will still need a symptom review every year.)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE *RIGHT NOW*:

☐ Chronic Cough (> 3 weeks) ☐ Fever ☐ Sputum Production ☐ Night Sweats ☐ Appetite Loss
☐ Malaise (slight/general feeling of not being well) ☐ Weight Loss ☐ Bloody Sputum ☐ Chest Pain
☐ **NONE OF THESE**

X_____	X_____	_____	_____
Signature	Date	Date Received in Office	OH Nurse Signature

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