Health Sciences
Tuberculosis Screening & Questionnaire
Quantum Gold/CXR/Positive PPD - Confidential

Last Reviewed 7/16/2018

This form is to be completed if PPD is positive or if there is a history of positive PPD. A record of negative Quantum Gold TB test within the last year, or chest x-ray within the past two years, must be included.

As of January 1, 1994, the Shasta County Public Health Department changed their policy regarding periodic Quantum Gold TB tests and chest x-rays for individuals with a past history of positive skin test for TB. The following questionnaire was developed in collaboration with the Shasta County Health Department, with the intent of your reviewing symptoms that might indicate active infection.

TO BE COMPLETED BY STUDENT	Please answer the following questions: (check Yes or No)	
During the past year, have you experienced any of the following symptoms:	**Yes**	**No**
1. Cough lasting more than 4 weeks and still present?		
2. Cough that brings up thick mucus from the lower chest?		
If yes, does the mucus ever have blood in it?		
3. Unexplained night sweats in which linens or bed clothes are wet and not related to environmental temperatures?		
4. Unexplained feeling of weakness or fatigue lasting longer than 4 weeks?		
5. Unexplained weight loss of 5-10 pounds?		
6. Unexplained low grade fever, on and off, lasting longer than 4 weeks?		

If you answered "yes" to any of the above questions, please see your physician for evaluation of symptoms consistent with possible Tuberculosis. If your private physician considers "Active Tuberculosis Disease" possible, please ask him or her to notify the Shasta County Health Department.

__________________________ __________________________ _____________
(Faculty Name Printed) (Faculty Signature) (Date)

TO BE COMPLETED BY MEDICAL PROVIDER

FOLLOW-UP MEDICAL EVALUATION

To be completed by Physician or Nurse Practitioner if any questions answered “yes” above.

The following examinations were completed to rule out active (contagious) tuberculosis:

[ ] Physical Exam Date __________ Findings ___________________________________
[ ] Chest X-ray Date __________ Findings ___________________________________
[ ] Quantum Gold TB Date __________ Findings ___________________________________
[ ] Sputum Date __________ Findings ___________________________________

The following treatment was initiated on ________________________ (date).
Name of Medication __________________________ Duration of Treatment ____________________

My examination of this individual **does** [ ] - **does not** [ ] reveal any communicable disease that would create a hazard to others. He/she may return to class and participate in clinical experiences on ___________ (date).

_____________________________ ______________________________ ______________
(Physician Name Printed) (Physician Signature) (Date)

PLEASE RETURN THIS QUESTIONNAIRE TO THE HEALTH SCIENCES OFFICE