



Tuberculosis Screening & Questionnaire

As per Health Sciences Program Policy - [Clinical Requirements](#), the result of an annual TB screening is required to be on file in the Health Sciences office. The TB Screening Questionnaire is required to be completed as a part of the TB Screening. Complete this form and have your healthcare provider document the results on the bottom of this form.

STOP! If you have ever had a positive TB test which required you to have a Quantum Gold TB test or chest x-ray, **you must not take further TB skin tests**. Please refer to the Clinical Requirements policy and/or talk with your healthcare provider or Health Services staff for more information. If you have had a BCG vaccine, you may be eligible to use the Quantum Gold TB test instead of chest x-ray and medical clearance.

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 (under 18 requires written parental consent) and agree to have a

Tuberculosis Screening Skin Test: _____
(Signature)

Date administered: _____ Result: Positive Negative

Attach a copy of the TB screening administration and interpretation form from your health care provider.