TOURO UNIVERSITY
CALIFORNIA

Form: C Initial TB Screen & Symptom Survey

Student completes the questionnaire. Must be reviewed and signed by the provider

Name _____ DOB:_____ Program/ Graduation Yr. _____

Please Print

Initial TB Screen & History

Yes ☐ No ☐ 1. Were you ever told you had a positive PPD skin test? If yes, enter the date _____

and size in _____ **mm induration**.

Yes ☐ No ☐ **2.** Can you provide a document your provider with the date and size of the PPD?

Yes ☐ No ☐ 3. Were you born in another country? If yes, where and when_____

Yes ☐ No ☐ 4. Did you ever get a **BCG** vaccine? If yes, when?_____

Yes ☐ No ☐ **5.** Have you ever had a IGRA blood test such as a TB quantiFERON gold or T-spot?

If yes, when _____ Was the test result pos ☐ neg ☐ or indeterminate ☐

Yes ☐ No ☐ 6. Have you ever been told you had latent TB infection (LTBI)?

Yes ☐ No ☐ 7. Have you ever taken INH or any other anti TB medication? If yes, name of medication (s)

_____ Date started _____ Date ended_____

Yes ☐ No ☐ 8. Can you provide documentation of having treatment with anti TB medication?

Yes ☐ No ☐ 9. Have you ever traveled outside of the country for a month or longer?

If yes, Where and when _____

Yes ☐ No ☐ 10. Has a family member, close friend or roommate ever been treated for tuberculosis?

Yes ☐ No ☐ 11. Have you ever lived, worked or volunteered in a residential setting, shelter or hospital?

If yes, where and when _____

Symptom Survey

The Symptom Survey is required annually for anyone with a current or past positive PPD.

During the past year have you had any of the following symptoms?

Unexplained weight loss?	Yes ☐ No ☐	Date of last CXR: _____ pos ☐ neg ☐
Decrease in appetite?	Yes ☐ No ☐	
Persistent cough?	Yes ☐ No ☐	
Blood streaked sputum?	Yes ☐ No ☐	Date of last QFT:_____ pos ☐ neg ☐
Night Sweats?	Yes ☐ No ☐	
Unexplained low grade fever?	Yes ☐ No ☐	
Swelling of the lymph nodes?	Yes ☐ No ☐	
Unusual tiredness or fatigue?	Yes ☐ No ☐	

Student's Signature: _____Date:_____

Providers Signature: _____ Date: _____

Provider's name

Providers address or stamp: