TOURO UNIVERSITY
CALIFORNIA

Form C: TB Symptom Survey

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

Name ____ DOB:_____________ Program/ Graduation Yr. ___________
Please Print

Phone: ________________________________

Annual 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 ☐
Decrease in appetite?	Yes ☐	No ☐
Persistent cough?	Yes ☐	No ☐
Blood streaked sputum?	Yes ☐	No ☐
Night Sweats?	Yes ☐	No ☐
Unexplained low grade fever?	Yes ☐	No ☐
Swelling of the lymph nodes?	Yes ☐	No ☐
Unusual tiredness or fatigue?	Yes ☐	No ☐

Date of last CXR: _____________ pos ☐ neg ☐

Date of last QFT: _____________ pos ☐ neg ☐

Student's Signature: ________________________________Date:__________________________

Provider's Signature: ________________________________ Date: __________________________

Provider's Printed Name: ____________________________

Providers address or stamp: