Form D: TB Symptoms Health Screening Checklist
This section to be completed by the student.
Please use ink and print clearly.

Class of __________ COM □ COP □ GSOE □ MSPAS/MPH □ MPH □

Name ___________________________ Gender: M□ F□ Date of Birth ___/___/_______

Date of PPD Placement_________________________ PPD Results__________ MM

Date of Quantiferon gold serum test:_________________ Results:__________________

Date of Last Chest X-Ray:_______________ Results:________ Positive for TB______ Negative for TB______

1. Have you ever been told you have active tuberculosis?   Yes□ No□
2. Have you ever taken INH or any other any other anti-TB drug?  Yes□ No□

If yes, list names:________________________________________________________________________

3. Date and duration of medication regime_______________________________________________ (months)

4. Have you ever had BCG Vaccination?    Yes □ No □    If yes, when? ____________________

5. During the past year have you noticed:
   ➢ Unexplained weight loss? ...................... Yes□ No□
   ➢ Decrease in your appetite?……………. Yes□ No□
   ➢ Cough not associated with cold or flu? .......... Yes□ No□
   ➢ Increase in AMOUNT of Sputum? ..……….. Yes□ No□
   ➢ Change in COLOR of Sputum? ................ Yes□ No□
   ➢ Change is CONSISTENCY of Sputum? .......... Yes□ No□
   ➢ Blood Streaked Sputum? ...................... Yes□ No□
   ➢ Night Sweats? ................................... Yes□ No□
   ➢ Unexplained low grade fever? ............... Yes□ No□
   ➢ Unusual tiredness or fatigue? ................. Yes□ No□
   ➢ Swelling of lymph nodes? ..................... Yes□ No□

6. Have you had contact with a family member or partner who has been diagnosed with tuberculosis?  Yes□ No□

7. Have you or a member of your family been exposed to someone who is immune compromised?  Yes□ No□

Explain any “Yes” answers above:_________________________________________________________________________________________

Signature of Student_____________________________________________ Date_______________________

Signature of Healthcare Provider___________________________________ Date_______________________

No Further Action Needed_______ Chest X-Ray Requested_______ Further Evaluation Needed_______

Revised 02/16/2012