POSITIVE TUBERCULOSIS TEST QUESTIONNAIRE

Name: _____ Department: _____
Date of Birth: _____ Phone: _____

Initial History (to be completed at first POSITIVE test)

Have you ever received the BCG vaccine? ☐ No ☐ Yes If Yes, when? _____
Have you ever been diagnosed with active TB? ☐ No ☐ Yes If Yes, when? _____
When did you first convert to a positive skin test? _____
Have you had a Quantiferon test? ☐ N ☐ Yes If yes, when? _____ Result: _____
Did you receive drug treatment? ☐ N ☐ Yes If yes, when? _____
What kind of medication did you take? _____
Who administered? _____
When was your most recent x-ray?

ANNUAL: Please note **any symptoms you have experienced in the past 6-12 months**

Anorexia (loss of appetite)	☐ No	☐ Yes	Productive cough combined with fever, chills, weakness, sweating, (not responsive to treatment)	☐ No	☐ Yes
Bloody or blood-streaked sputum	☐ No	☐ Yes			
Chronic cough (>2 weeks)	☐ No	☐ Yes			
Fatigue	☐ No	☐ Yes	Shortness of breath	☐ No	☐ Yes
Low-grade fevers	☐ No	☐ Yes	Unexplained weight loss	☐ No	☐ Yes
Night sweats	☐ No	☐ Yes	Unusual or irregular menses	☐ No	☐ Yes

1. Have you ever had household contact with a person who has active TB disease? ☐ No ☐ Yes
   If Yes, who? _____ When? _____
2. Have you had recent contact with anyone known to have active TB? ☐ No ☐ Yes
   If Yes, who? _____ When? _____
3. Are you on oral cortisone or other related anti-inflammatory medication? ☐ No ☐ Yes
   If Yes, explain:

_____ _____
Student/Employee Signature Date

_____ _____
CHS Reviewed by: Date

Please FAX completed form to Campus Health Service Medical Records Department at 520-626-4301