INDIANA UNIVERSITY SOUTH BEND

HEALTH AND WELLNESS CENTER

Vera Z. Dwyer College of Health Sciences

Annual Tuberculosis Screening and Surveillance Questionnaire

Name: (Last, First Middle Initial): _____

Date of Birth: _____ **University ID #:** _____

Have you had:	**Yes**	**No**
TB or a positive skin test?		
An immune disease?		
Taking steroids or cancer medications?		
Received a live virus vaccine in the last two months?		
Had preventative immunization for TB with BCG vaccine?		
Had a recent viral infection?		
Been in contact with anyone with active TB disease?		

Are you currently experiencing any of the following:	**Yes**	**No**
Productive cough longer than two weeks.		
Blood in sputum.		
Unexplained fever.		
Shortness of breath.		
Chest pain.		
Unexplained weight loss.		
Unexplained fatigue.		
Hoarseness.		

Are you taking any new medications? If so, please provide type and dosage.

_____

Any changes of your health status? If so, what?

_____

Are you taking any new medications? If so, please provide type and dosage.

_____

I understand that the skin test must be read in 48-72 hours. I hereby consent to Tuberculin Skin Testing. (TST)

Signature: _____ Date: _____

Lot Number: _____ Expiration: _____ Left/Right Forearm

TST given on (date): _____ Time: _____ Given by: _____

TST read on (date) Time: _____ Induration size: _____mm Read by: _____

If needed (must attach results):

QuantiFERON Gold: _____ Chest X-ray (must be within three years): _____