VERA Z. DWYER COLLEGE OF HEALTH SCIENCES

INDIANA UNIVERSITY SOUTH BEND

School of Nursing

TB Questionnaire

This form is to be completed on an annual basis by all students who have a history of positive PPD or have a negative PPD on file since starting the program. If you have been exposed to TB, a PPD is required.

In the preceding year, have you had:	YES	NO
1. Unexplained weight loss?	☐	☐
2. Persistent or chronic cough?	☐	☐
3. Night sweats?	☐	☐
4. Fever associated with one of the above and not explained by other illnesses, i.e., cold, flu?	☐	☐
5. Had a recent chest x-ray ordered by your physician?	☐	☐

6. Specify any illness you have had and/or medications you have taken in the past year:

_____

_____

Purpose of medication: _____

_____

Comments: _____

_____

Negative chest x-ray on record ☐ Date of x-ray: _____

_____

Student Signature Date

Return to the IUSB Office of Nursing Student Services, NS 416. This questionnaire is for your protection and the protection of patients, and will be kept in your student record. It must be signed annually.