

SIGN/SYMPTOM SCREENING for TUBERCULOSIS
REQUIRED ONLY FOR STUDENTS WHO HAVE HAD FALSE POSITIVE TB SKIN TEST RESULTS

DATE _____

NAME _____

SIGNS AND SYMPTOMS OF TUBERCULOSIS REVIEWED WITH PATIENT:

SIGN / SYMPTOM OF TB	YES	NO
LOSS OF APPETITE	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>
HEMOPTYSIS	<input type="checkbox"/>	<input type="checkbox"/>
UNEXPLAINED FEVER	<input type="checkbox"/>	<input type="checkbox"/>
NIGHT SWEATS	<input type="checkbox"/>	<input type="checkbox"/>
PRODUCTIVE COUGH FOR 2-3 WEEKS	<input type="checkbox"/>	<input type="checkbox"/>
WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>
UNEXPLAINED WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>

I understand that if I develop two or more signs and/or symptoms of Tuberculosis, I will be evaluated (including a chest X-ray) by a physician for possible active Tuberculosis disease.

 SIGNATURE AND CREDENTIALS OF MEDICAL PROFESSIONAL REVIEWING

 SIGNATURE OF PATIENT

NAME/ADDRESS/PHONE OF PROVIDER:
