College of Nursing
3800 Victory Parkway
Cincinnati, OH 45207-7351
513 745-3814

**TB QUESTIONNAIRE REQUIRED ANNUALLY**

For students with: A positive tuberculosis skin or blood test result AND negative/clear chest x-ray.

DATE_____

NAME_____

SIGNS AND SYMPTOMS OF TUBERCULOSIS REVIEWED WITH PATIENT:

| **SIGN / SYMPTOM OF TB** | **YES** | **NO** |
|---|---|---|
| LOSS OF APPETITE | ☐ | ☐ |
| CHEST PAIN | ☐ | ☐ |
| FATIGUE | ☐ | ☐ |
| HEMOPTYSIS | ☐ | ☐ |
| UNEXPLAINED FEVER | ☐ | ☐ |
| NIGHT SWEATS | ☐ | ☐ |
| PRODUCTIVE COUGH FOR 2-3 WEEKS | ☐ | ☐ |
| WEAKNESS | ☐ | ☐ |
| UNEXPLAINED WEIGHT LOSS | ☐ | ☐ |

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:

_____

Source: Symptom Screen, Hamilton County TB Control, 2019