SCHOOL OF NURSING
UT HEALTH SCIENCE CENTER®
STUDENT HEALTH CENTER

Student Health Center
Phone: (210) 567-9355
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TB Screening Questionnaire

Last Name	First Name	Date	Date of Birth	Badge Number

When was your last TB Skin test or Blood Assay? _________Result ___________

When was your last Chest x-ray? ____________________________

Have you had the BCG vaccine [ ] Yes [ ] No If yes, Country? __________

Since you last TB screening, have you worked/volunteered in a location where patients with active TB receive care or service? [ ] Yes [ ] No [ ] Don't know

Since your last TB screening, have you traveled outside the US? [ ] Yes [ ] No
if Yes When and Where? ___________________________

Since your last TB screening, have you lived with or had close contact with someone with TB disease?
[ ] Yes [ ] No [ ] Don't know

Do you work, volunteer or live in a facility that provides medical or social services? [ ] Yes [ ] No [ ] Don't know

Have you been treated for TB disease before or taken TB prophylaxis medication? [ ] Yes [ ] No [ ] Don't know

If yes, what medication? __________________ How long did you take the medication? _____________________

Are you taking any TB medications currently? ______________________________

Since your last Tb screening, have you had any of the following symptoms for more than 3 weeks at a time?

[ ] persistent cough [ ] Unexplained weight loss [ ] Excessive fatigue [ ] persistent fever [ ] Coughing up blood
[ ] Night sweats [ ] Loss of appetite [ ] None of the above

Do you have history of any of the following?

[ ] Liver disease [ ] kidney disease [ ] diabetes [ ] Hepatitis B exposure [ ] Steroid use [ ] Cancer
[ ] Any immune comprising illness [ ] Excessive fatigue [ ] None of the above

Additional follow-up required due to findings? [ ] Yes [ ] No

If yes, explain ____

To be completed By Provider (MD, DO, NP, PA)

Printed Name: _______________________________________ Signature: _____________________________________

Address and phone number of the clinic: ____