UTHealth North Campus Tyler

UNIVERSITY HEALTH CLINIC – PATRIOT DRIVE

TB Screening Questionnaire

Circle: New Student / Annual / Post Exposure

Last Name_____ First Name_____ MI_____
DOB: _____ Date of Hire: _____
Date Form Complete___/_____/_____ Department:_____
Degree Program _____ Phone:_____

1. Since your last TB review, have you worked in a location where patients with active TB received care or service?
[ ] Yes [ ] No [ ] Don't know
2. Since your last TB review, have you lived with or had close contact with someone who has TB disease?
[ ] Yes [ ] No [ ] Don't know Source: _____
3. Since your last TB review, have had an abnormal chest x-ray?
[ ] Yes [ ] No [ ] Don't know
4. Since your last TB review, has a health practitioner told you that your immune system is weak, compromised or can't fight infection?
[ ] Yes [ ] No [ ] Don't know
5. Do you work, volunteer, or live in another facility that provides medical or social services?
[ ] Yes [ ] No
6. Since your last TB review, have you traveled outside the U.S.A.?
[ ] Yes [ ] No If yes, where and when? _____
7. Have you ever had any of the following symptoms for more than 3 weeks at a time?
(*Please check all that apply*)
[ ] Persistent coughing [ ] Excessive fatigue [ ] Coughing up blood
[ ] Hoarseness [ ] Excessive sweating at night [ ] Persistent fever
[ ] Loss of Appetite [ ] Excessive weight loss (≥ 10% of ideal wt)
[ ] **NONE OF THE ABOVE**

If you have checked any of the above symptoms, please describe in further detail:
(Onset date, any medical treatment received, did treatment resolve symptom(s):_____

8. Are you a diabetic?
[ ] Yes [ ] No
9. Do you have silicosis, chronic renal failure, leukemia, lymphoma, HIV, carcinoma of the head, neck, or lung?
[ ] Yes [ ] No
10. Have you had a gastrectomy or jejunoileal bypass? [ ] Yes [ ] No
11. Are you an organ recipient? [ ] Yes [ ] No
12. Are you pregnant? [ ] Yes [ ] No
13. Are you under 17 years of age? [ ] Yes [ ] No
14. Do you smoke? [ ] Yes [ ] No
15. Do you take immunosuppressive drugs? (e.g., prednisone, chemotherapy) [ ] Yes [ ] No
If yes please list name of medication and dosage: _____
16. When was your last TB test? _____
17. Have you ever had a positive TB test? [ ] Yes [ ] No
If yes, have you ever been treated for TB Latent TB Infection (LTBI)? [ ] Yes [ ] No
If yes, did you complete treatment for LTBI? [ ] Yes [ ] No
18. Have you ever been diagnosed with having TB disease? [ ] Yes [ ] No
If yes, were you treated for TB disease? [ ] Yes [ ] No
If yes, did you complete treatment for TB disease? [ ] Yes [ ] No

THE ABOVE INFORMATION IS ACCURATE AND CORRECT: _____
STUDENT SIGNATURE/DATE

I have read or a provider has explained to me the information about Quantiferon TB testing. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of having a Quantiferon test and agree to have the test performed._____
STUDENT SIGNATURE/DATE

Office use (completed by the University Health Clinic nurse)
Quantiferon TB results and date of results:_____
Additional follow-up due to findings:
Was employee referred for further evaluation? [ ] Yes [ ] No [ ] Refused
If yes, to whom:_____ Referral Date:_____
CXR results: normal abnormal

Medication Prescribed: [ ] Yes [ ] No

Provider Recommendations:

PROVIDER SIGNATURE/DATE