**Annual TB Screening Questionnaire**

**Section A**

1. Do you have a history of having Tuberculosis?
   - [ ] Yes  [ ] No
   *If YES, complete sections A and B*

2. Do you have a history of positive TB skin test, Quantiferon-TB Gold or T-SPOT?
   - [ ] Yes  [ ] No
   *If YES, complete sections A and B*

3. Do you now have any condition requiring prolonged steroid or immunosuppressive therapy?
   - [ ] Yes  [ ] No

4. Do you have an immunosuppressive illness at the present time?
   - [ ] Yes  [ ] No

5. Have you had any of the following in the past year?
   - a. Recent, close contact with anyone having active tuberculosis?
     - [ ] Yes  [ ] No
   - b. Unexplained cough?
     - [ ] Yes  [ ] No
   - c. Coughing up blood?
     - [ ] Yes  [ ] No
   - d. Unexplained weight loss or increased fatigue?
     - [ ] Yes  [ ] No
   - e. Unexplained fever or night sweats?
     - [ ] Yes  [ ] No
   - f. Have you ever had BCG vaccine?
     - [ ] Yes  [ ] No

**Section B**

1. Did you have a chest xray done?
   - [ ] Yes  [ ] No
   a. Date of last chest xray:
   - [ ] Yes  [ ] No
   b. Was the chest xray normal?
   - [ ] Yes  [ ] No
   2. Were you ever treated for TB?
   - [ ] Yes  [ ] No
   a. Year treated for TB:
   - [ ] Yes  [ ] No
   b. What medicine/s did you take? Circle all that apply:
     - Isoniazid (INH)
     - Rifampin (RIF)
     - Ethambutol (EMB)
     - Pyrazinamide (PZA)
     - Other:
   c. If you did not complete at least six months of therapy
   - [ ] Yes  [ ] No
   Please explain why:

**Have you had a live vaccine in the last 30 days?**

- [ ] Yes  [ ] No

I hereby consent to the injection of tuberculin PPD skin test. I understand that my PPD skin test must be read and documented by a physician or physician representative **48 – 72 hours** after the injection. This form **must** be returned to University Health Services.

**Signature:**

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**STOP HERE**

(If you have documentation of a positive PPD on file with University Health Services, you are not required to complete section C.)

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### ONE - STEP

**DATE ADMINISTERED:**

Administered by:

**DATE READ:**

Read by:

**DOSE/ROUTE:** 0.1ML/intradermal

**MFR/LOT/EXP DATE:**

**SITE:** Left Forearm: [ ] Right Forearm: [ ]

**RESULT:** [ ] Positive  [ ] Negative

**MM INDURATION:**

Office Stamp Required:

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### TWO - STEP (when applicable)

**DATE ADMINISTERED:**

Administered by:

**DATE READ:**

Read by:

**DOSE/ROUTE:** 0.1ML/intradermal

**MFR/LOT/EXP DATE:**

**SITE:** Left Forearm: [ ] Right Forearm: [ ]

**RESULT:** [ ] Positive  [ ] Negative

**MM INDURATION:**

Office Stamp Required: