University Health Services
University of Cincinnati
Lindner Athletic Center, 3rd floor, room 335
Cincinnati, OH 45221-0010
Phone: 513-556-2564 **Fax: 513-556-6655**

Annual TB Screening Questionnaire

Name: _____ **Today's date:** _____/_____/_____
(Please print)

Birth date: _____/_____/_____ M #_____ Phone: _____

Please check: ❑ 1st year student ❑ 2nd year student ❑ 3rd year student ❑ 4th year student

Section A				
1	Do you have a history of having Tuberculosis? **If YES, complete sections A and B**	❑ Yes	❑ No	
2	Do you have a history of positive TB skin test, QuantiFERON-TB Gold or T-SPOT? **If YES, complete sections A and B**	❑ Yes	❑ No	
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?**	❑ Yes	❑ No	
a	Recent, close contact with any person 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	
6	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 :		
b	Was the chest xray normal?	❑ Yes	❑ No
2	Were you ever treated for TB?	❑ Yes	❑ No
a	Year treated for TB:		
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		
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: _____

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

Section C	ONE - STEP	TWO – STEP (when applicable)
	DATE ADMINISTERED:	**DATE ADMINISTERED:**
	Administered by:	**Administered by:**
	DATE READ:	**DATE READ:**
	Read by:	**Read by:**
	DOSE/ROUTE : *0.1ML/intradermal*	**DOSE/ROUTE :** *0.1ML/intradermal*
	MFR/LOT/EXP DATE:	**MFR/LOT/EXP DATE:**
	SITE: Left Forearm: ❑ **Right Forearm:** ❑	**SITE: Left Forearm:** ❑ **Right Forearm:** ❑
	RESULT: ❑ Positive ❑ Negative	**RESULT:** ❑ Positive ❑ Negative
	MM INDURATION:	**MM INDURATION:**
	Office Stamp Required:	**Office Stamp Required:**