Banner Health

POSITIVE TB QUESTIONNAIRE

Name _____ **DOB** _____

School/Company _____ **Program/ID#** _____

Test Reason _____

Date of first Positive TST _____ ☐Recent Converter

Date of last CXR _____ CXR Status _____

Treatment ☐Medication _____

Do you have any of the following symptoms for 3 weeks or longer?			
Yes	*No*	*Symptom*	*Explanation if Yes*
☐	☐	Chronic Cough	
☐	☐	Production of Sputum	
☐	☐	Unexplained Weight Loss	
☐	☐	Unexplained Fever	
☐	☐	Unexplained Night Sweats	
☐	☐	Unexplained Weakness/Fatigue	
☐	☐	Shortness of Breath	
☐	☐	Any Serious Illness	

Date Symptoms were first detected _____

Are you taking any medication, specifically prednisone, or other steroids that depress your immune system?

Do you have any medical conditions like Diabetes, blood disorders or infections, Lupus or other immune disorders?

Student/Employee Signature _____ **Date** _____

In my medical opinion this individual is free from active tuberculosis disease
Provider Signature _____ **Date** _____

Student/Employee Comments:

Staff/ Provider Comments: