UAB Annual Tuberculosis Screening Questionnaire
For Medical/Health Related Students With Positive PPDs

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Student’s Name:

( Print): Last/Family, First MI

Social/Student #: Date:

Instructions: Please answer the following questions truthfully. Fill-in or circle the appropriate answers please:

1. How many millimeters was your positive PPD test (if known): mm Date: Y / N
2. Have you ever taken the BCG vaccine? Y / N
3. When was your last Chest X-Ray (CXR) taken: Y / N
4. Did you successfully complete 6 months of INH chemoprophylaxis therapy? Y / N
5. If yes where and when? Dates: Y / N
6. If no, reason for not taking the INH protocol:

7. Have you experienced any of the following symptoms within the past year?:
   a. Persistent productive cough? Y / N
   b. Coughing up blood? Y / N
   c. Chest pain? Y / N
   d. Shortness of breath/difficulty breathing? Y / N
   e. Unexplained fever lasting more than 3 days? Y / N
   f. Unexplained night sweats? Y / N
   g. Unexplained sudden weight loss? Y / N
   h. Unexplained fatigue/run down feeling? Y / N

8. Have you sought medical care for chest symptoms within the past year? Y / N
9. Have you ever had a positive HIV test? Y / N
10. Have you ever used illegal intravenous drugs? Y / N
11. Have you lived with or been in close contact with someone who had TB disease? Y / N
12. Considering the list of countries/continents below:
   a. Africa
   b. Asia: China, Mongolia, Vietnam, Korea, Indonesia, India, Pakistan & Bangladesh
   c. Eastern Europe: Russia and former Soviet Union States, Armenia
   d. Latin America: Mexico, Guatemala, South America
   e. Caribbean Islands: Jamaica, Dominican Republic, Haiti, Cuba, Trinidad & Tobago
   f. Pacific Islands including the Philippines; excluding Hawaii
      1. Were you born in one of these countries? Y / N
      2. Have you stayed in one of these places for one month or longer? Y / N
      3. Have you lived with or been in close contact with someone who stayed
         or lived in one of these countries for one month or longer? Y / N

If you answered yes to any of the above questions please explain:

________________________________________________________________________
________________________________________________________________________

I certify that the information contained on this TB Questionnaire is true and correct. I hereby understand
that if any of the above responses are “Yes” that I will be re-evaluated by a Student Health Provider to
rule out the presence of active tuberculosis. Furthermore, I may be required to have a current chest
film done and lab testing to obtain a clearance from Student Health Services.

Student/Patient Signature & Date: ____________________________ Date: ____________

SHS Signature & Date: ____________________________ Date: ____________