High Risk and Annual TB Questionnaire

Please circle your answer to the following questions:

1. Have you experienced any of the following symptoms within the past year?
   - Persistent productive cough? YES NO
   - Coughing up blood? YES NO
   - Chest pain? YES NO
   - Shortness of breath/difficulty breathing? YES NO
   - Unexplained fever lasting more than 3 days? YES NO
   - Unexplained night sweats? YES NO
   - Unexplained sudden weight loss? YES NO
   - Unexplained fatigue/run down feeling? YES NO
   - Unexplained swollen lymph nodes or masses in your armpit or neck area? YES NO

2. Have you ever had a positive HIV test? YES NO

3. Are you on medications that suppress the immune system? YES NO

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

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I certify that the information contained on this TB Questionnaire is true and accurate. 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 medical clearance.

________________________________________  ________________________________
Signature                                        Date