UAB STUDENT HEALTH SERVICES

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