THE UNIVERSITY OF ARIZONA®

CAMPUS HEALTH SERVICE

POSITIVE TUBERCULOSIS TEST QUESTIONNAIRE

Name: _____	Department: _____
Date of Birth: _____	Phone: _____

INITIAL HISTORY (To be completed at first positive test.)

Have you ever received the BCG vaccine? Yes No When? _____

Have you ever been diagnosed with active TB? Yes No

Did you receive drug treatment? Yes No When? _____

What kind of medication do you take? _____

When did you first convert to a positive skin test? _____

Where you treated with medication? Yes No When? _____

Who administered? _____ What kind of medication? _____

When was your most recent chest xray? _____ Was it ***abnormal***? Yes No

Have you had a QuantiFeron Test? If yes, when? _____ Result Negative Positive

ANNUAL: Please note any symptoms you have experienced in the past 6 – 12 months.

Fatigue	Yes No	Anorexia (loss of appetite)	Yes No
Unexplained Weight Loss	Yes No	Unusual or irregular menses	Yes No
Low grade fevers	Yes No	Night sweats	Yes No
Productive cough combined with fever, chills, weakness, sweating (not responsive to treatment)	Yes No	Chronic cough (>2 weeks)	Yes No
Bloody or blood-streaked sputum	Yes No	Shortness of breath, wheezing	Yes No

1. Have you ever had household contact with a person who has active TB disease? Yes No

   If Yes, who? _____When? _____

2. Have you had recent contact with anyone known to have active TB? Yes No

   If Yes, who? _____ When? _____

3. Are you on oral cortisone or other related anti-inflammatory medication? Yes No

   Any Yes, explain: _____

_____

_____

_____ _____

Signature Date

This section to be completed by CHS Staff

Last CXR on file:	Signature CHS Review:	Date:
CXR Order date:	Person Requesting CXR: MD/RN	Result:
CHS Referrals:		