UMB Student & Employee Health

Tuberculosis (TB) Questionnaire Form For Positive *TST

Date: _____ Name: _____ Signature: _____

DOB: _____ Phone #: _____-_____-_____ School/Depart: _____

School ID #: _____ Year & Semester Entered: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever:

Had active TB	Yes	No
Taken medication for TB exposure	Yes	No
Had a reaction to TB skin test	Yes	No
Been told you had a weakened immune system	Yes	No

Do you CURRENTLY have any of the following?

Persistent cough	Yes	No
Night sweats	Yes	No
Unexplained weight loss	Yes	No
Unexplained tiredness	Yes	No
Persistent fever	Yes	No
Hoarseness	Yes	No

Have you ever received BCG vaccination?	Yes	No
Were you born in the USA?	Yes	No

If no, what is your country of origin? _____

Since your last TB skin test or TB questionnaire:

Have you had exposure to anyone with known TB disease?	Yes	No
Have you had and abnormal chest x-ray?	Yes	No

When was your first positive TB skin test? _____

When was your most recent chest x-ray? _____

Was your most recent chest x-ray normal? _____

Explain any yes answers: _____

_____

_____

Updated 06/26/15 drm

*Tuberculin skin test