STUDENT HEALTH SERVICES
UNIVERSITY OF THE PACIFIC

Student Name: _____
Student ID #: _____
Phone #: _____

Annual Tuberculosis Screening Questionnaire

Health Profession Majors/Athletes

Have you:

1. Ever had a positive TB test? ☐ Yes ☐ No
2. Ever had a BCG vaccine? ☐ Yes ☐ No
3. Ever been treated with INH? ☐ Yes ☐ No
   a. If yes, dates given: _____
4. Had any vaccinations administered in the past 4 weeks? ☐ Yes ☐ No
5. Had any chronic or recurrent symptoms *lasting 3 weeks or longer*:
   a. Productive cough? ☐ Yes ☐ No
   b. Cough or spit up blood? ☐ Yes ☐ No
   c. Unexplained or recurrent fever, chills or night sweats? ☐ Yes ☐ No
   d. Unexplained fatigue? ☐ Yes ☐ No
   e. Chest pain? ☐ Yes ☐ No
   f. Unexpected weight loss or loss of appetite? ☐ Yes ☐ No
6. Had a health practitioner tell you that your immune system is suppressed? ☐ Yes ☐ No
7. Traveled overseas for more than 2 weeks in the last 12 months? ☐ Yes ☐ No
8. Been exposed to a family, volunteer and/or employee of high-risk congregate settings to TB in the last 12 month? (Ex: correctional facilities, long-term care facilities, homeless shelter) ☐ Yes ☐ No

Explain any *Yes* answers _____
_____

☐ ***I declare that my answers/statements are correctly recorded, complete and true to the best of my knowledge.***

Student Signature: _____ Date: _____

To be completed by Health Service Staff:

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

☐ Cleared – No indication of active tuberculosis at this time

☐ Further evaluation needed: ☐ TB Skin Test ☐ Chest X-ray

Reviewed by: _____ Date: _____

Submit documentation: Medical Portal (go.pacific.edu/myhealth)>Downloadable Forms Tab>Additional Immunization Records Category