TB Questionnaire

Mail completed form to:
University of Detroit Mercy
Student Health Center
4001 W. McNichols Road
Detroit, MI 48221-3038

Dear Student:
Please complete and submit this form to the University of Detroit Mercy. It is due before the first day of classes or a hold will be placed on your account. If you have any questions, please call the Student Health Center at 313-993-1185. Thank you in advance for your cooperation.

Name: _____ Student ID:_____ Date: _____

Phone Number:_____ E-mail:_____

The information I have given is true and accurate to the best of my knowledge.

Signature:_____

If you answer "Yes" to one or more of the following questions, you must submit this form with documentation of a recent (within the past year) TB test (see below). **If all answers are no**, please sign above and mail just this form. Please send all forms and documentation to **University of Detroit Mercy, Student Health Center, 4001 W. McNichols, Detroit, MI 48221**.

1. Have you ever had a positive TB skin test? ❑ Yes ❑ No
2. Have you had close contact with anyone who was sick with tuberculosis? ❑ Yes ❑ No
3. Were you born in, or have you traveled to, one of the countries on the list below? ❑ Yes ❑ No

Afghanistan	Central African Republic	Ghana	Malawi	Pakistan	Somalia
Algeria	Chad	Guam	Malaysia	Palau	South Africa
Angola	China	Guatemala	Maldives	Papua New Guinea	Sri Lanka
Argentina	China, Hong Kong SAR	Guinea	Mali	Paraguay	Sudan
Armenia	China, Macao SAR	Guinea-Bissau	Marshall Islands	Peru	Suriname
Azerbaijan	Colombia	Guyana	Mauritania	Philippines	Swaziland
Bangladesh	Comoros	Haiti	Mauritius	Qatar	Tajikistan
Belarus	Congo	Honduras	Mexico	Rep. of Korea	Thailand
Belize	Côte d'Ivoire	India	Micronesia	Poland	Togo
Benin	Djibouti	Indonesia	Mongolia	Portugal	Turkmenistan
Bhutan	Dominican Republic	Iraq	Morocco	Rep. Korea	Tuvalu
Bolivia	DPR Korea	Kazakhstan	Mozambique	Republic of Moldova	Uganda
Bosnia & Herzegovina	DR Congo	Kenya	Myanmar	Romania	Ukraine
Botswana	Ecuador	Kiribati	Namibia	Russian Federation	UR Tanzania
Brazil	El Salvador	Kyrgyzstan	Nauru	Rwanda	Uzbekistan
Brunei Darussalam	Equatorial Guinea	Lao PDR	Nepal	Sao Tome and Principe	Vanuatu
Burkina Faso	Eritrea	Latvia	Nicaragua	Saudi Arabia	Viet Nam
Burundi	Ethiopia	Lesotho	Niger	Senegal	Wallis & Futuna
Cambodia	Gabon	Liberia	Nigeria	Seychelles	Yemen
Cameroon	Gambia	Lithuania	Niue	Sierra Leone	Zambia
Cape Verde	Georgia	Madagascar	Northern Mariana Island	Solomon Islands	Zimbabwe

If you answered YES to ANY of the above questions, you are required to have your Health Care Provider administer a TB test and complete this section. The form needs to be returned in the postage-paid envelope or to the address above.

PPD Test date:_____ Results: _____ mm induration Negative ❑ Positive ❑
IF POSITIVE, PLEASE SEE BELOW.

Provider's Printed Name:_____ Signature:_____ Phone: _____

If the PPD test is POSITIVE, please have your Health Care Provider complete the information below.

Chest X-Ray test date: _____ Results: Negative ❑ Positive ❑ Other: _____
Were you counseled on TB Medication? ❑ Yes ❑ No
Did you decline TB medication? ❑ Yes ❑ No
Did you take or are you presently taking TB medication? ❑ Yes ❑ No

If yes, please indicate: START DATE: _____ (mm/day/year) STOP DATE: _____ (mm/day/year)

Provider's Printed Name:_____ Signature:_____ Phone: _____