UAB Student Health Services High Risk and Annual TB Questionnaire

Student Health and Wellness, 1714 9th Avenue South, LRC Suite 300, Birmingham, Alabama 35294-1270
Phone: 205-934-3580, Fax: 205-996-7468

Student's Name: _____
(Print): Last/Family First MI

Student ID#/B0: _____ **Date:** _____

Please answer the following questions:

1. Have you experienced any of the following symptoms within the past year?
   a. Persistent productive cough? ……..... Y / N
   b. Coughing up blood? ...……..... Y / N
   c. Chest pain? ……. Y / N
   d. Shortness of breath/difficulty breathing? ……...…… Y / N
   e. Unexplained fever lasting more than 3 days? ……... Y / N
   f. Unexplained night sweats? …… Y / N
   g. Unexplained sudden weight loss? ……..…… Y / N
   h. Unexplained fatigue/run down feeling? ……..…….. Y / N
   i. Unexplained swollen lymph nodes or masses in your armpit or neck area?.. Y / N

2. Have you ever had a positive HIV test? ……..……. Y / N

3. Are you on medications that suppress the immune system? ……..… Y / N

If you answered yes to any of the above questions, please explain:
_____
_____
_____

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.

Student/Patient Signature: _____ Date: _____

SHS Signature: _____ Date: _____