UNION
COLLEGE
*Experience the Spirit*

# Tuberculosis Screening Questionnaire

Student/Employee Name_____ Date_____

Please indicate whether or not you are experiencing any of the following signs or symptoms:

| | | |
|---|---|---|
| Productive cough lasting longer than three weeks | yes ____ | no ____ |
| Coughing up blood | yes ____ | no ____ |
| Hoarseness | yes ____ | no ____ |
| Fever/chills | yes ____ | no ____ |
| Night sweats | yes ____ | no ____ |
| Unexplained weight loss | yes ____ | no ____ |
| Loss of appetite | yes ____ | no ____ |
| Shortness of breath | yes ____ | no ____ |
| Increased fatigue (feeling tired) | yes ____ | no ____ |
| Exposure to TB in last two years | yes ____ | no ____ |

Have you ever had a positive TB skin test? yes____ no____
If yes, please give date_____

Where were you living when the test was done? _____

Have you ever been given a BCG vaccine? yes ____ no ____
If yes, please give date_____

Have you ever had a T-spot or Quantiferon lab test done? yes____ no____
If yes, please give date_____

What were results of above lab test? _____

Have you ever had a Chest X-Ray taken to check for TB? yes ____ no ____
If yes, please give date_____

What were the results of your Chest X-Ray? _____

Were you given prophylactic treatment? yes____ no____
List name of medication: _____Date of initiation_____ Date of completion_____

**Incoming students:** get this item checked off your Registration Checklist by uploading it on your student portal webpage under "Health Documents".