
California State University San Bernardino/Department of Nursing

Annual Health Screening Questionnaire for History of Positive TB Skin Test

Instructions: Annual symptom screening is required for all students who have a history of a positive tuberculosis skin test [PPD skin test]. Students are required to see a licensed healthcare provider for symptom screening and completion of this form yearly only if they have a history of a positive TB skin test.

When did you convert to a positive PPD? _____

What is the date of your last chest x-ray? _____

Result:

Do you CURRENTLY have symptoms of:

	YES	NO
Weight loss [unrelated to dieting]	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite for > 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats/fever	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue for > 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough for > 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>

Answering "yes" to any of the above questions constitutes a positive screening evaluation and requires further treatment as recommended by your health care provider.

I am aware that misrepresentation of health information may result in dismissal from the program. I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Signature _____

Date _____

Print Name _____

Student ID# _____

**Health Care Provider verifying information [THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER]
-Nurse Practitioner, Physician, Registered Nurse, Physician's Assistant or a public health official-**

Name of Health Care Provider [Print]

Telephone [area code + number]

Signature of Health Care Provider

Date

Address of Health Care Provider