UCSF Student Health & Counseling
Student Academic Affairs

Confidential TB History and Symptom Review Form

Name ______________________ Date of Birth ______________________ School and Level (ex: Med 3) ______________________

TB HISTORY

Have you ever had a positive TB screening? yes no If yes, indicate which test(s) was/were positive:

Tuberculin Skin Test (PPD)______________QuantiFERON___________T.Spot__________________

Country of birth___________________________ Did you receive BCG vaccine as a child? yes no

Have you ever been prescribed INH? yes no Have you ever had an abnormal chest x-ray? yes no

Do you have diabetes, HIV, or another chronic condition that impairs your immune response? yes no

Do you take immunosuppressive medication? yes no Comments__________________________

TB EXPOSURE RISK

1. Since your last screening, have any of your roommates, friends, or family members been diagnosed with active tuberculosis? ☐ Yes ☐ No
2. Since your last screening, have you cared for a TB patient without wearing an N95 mask? ☐ Yes ☐ No
3. Since your last screening, have you traveled outside the USA? ☐ Yes ☐ No

   If yes, where?____

TB SYMPTOM REVIEW

Since your last screening, have you experienced any of the following:

4. Cough or chest pain that lasted longer than 3 weeks? ☐ Yes ☐ No
5. Fever that lasted longer than 3 weeks? ☐ Yes ☐ No
6. Coughing up blood? ☐ Yes ☐ No
7. Excessive sweating at night? ☐ Yes ☐ No
8. Unexplained weight loss? ☐ Yes ☐ No
9. Unexplained increase in weakness/fatigue? ☐ Yes ☐ No

STUDENT SIGNATURE ______________________ Date ________ **RN SIGNATURE** ______________________ Date ________

Return form to:

UCSF Student Health & Counseling, 500 Parnassus Ave., Millberry Union, Level P8, Rm. 5
Tel: 415.476.1281 Fax: 415.476.6137 (If you do not need a TB test, you may return form by FAX.)

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