Boonshoft School of Medicine
WRIGHT STATE UNIVERSITY

Annual TB Questionnaire

Student

Name: _____ Date: _____

Date of birth: _____ UID: _____

Please check if you have any of the following:	Yes	No
Previous positive TB test		
BCG vaccine		
Active TB		
INH (Isoniazid) medication (current or past)		

Have you experienced any of the following symptoms?	Yes	No
New, productive cough lasting three weeks or more		
Coughing up blood		
Hoarseness lasting three weeks or more		
Unintentional weight loss over the past two months		
Fever and/or chills lasting more than one week		
Prolonged loss of appetite		
Night sweats lasting more than one week		
Unusual or excessive tiredness over the past three weeks		
Swollen glands		
Recurrent urinary infections or blood in the urine		
Shortness of breath		

Heath Care Provider

I certify that the student does NOT show signs of active TB disease.

Name: _____ Date: _____

Street address: _____

City, State & Zip: _____

Phone: _____

Signature: _____