Herbert Wertheim College of Medicine

FLORIDA INTERNATIONAL UNIVERSITY

Tuberculosis Screening Questionnaire

Student Name: ______________________________________ **Date:** ________________

	YES*	NO
Has anyone in your family or other close contact had tuberculosis (TB)?		
Have you ever been on medication to treat TB?		
Have you ever had a BCTG vaccination? If yes, when? Date: _______________		

Have you had any of the following symptoms in the past month?

	YES*	NO
Chronic cough (more than three weeks)		
Fever/chills		
Unexplained weight loss		
Excessive fatigue or weakness daily		
Spitting or coughing up blood		
Night sweats		
Loss of appetite		

** Please explain any "Yes" responses below – continue on separate sheet if necessary.*

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The information I have provided in this form is accurate to the best of my knowledge. I acknowledge that the FIU Herbert Wertheim College of Medicine is not responsible for any information I omit.

Signature of Student: ____ Date: ____________

Physician's Signature: ____

OFFICE STAMP:

Printed Name of Physician: _________________________________ Date: ________________

Office Phone: ____

Office Address: ____

If your PPD test is positive, this form must be completed annually in lieu of receiving annual Chest X-rays.

Upload this form to your American DataBank online account.