

UISD Tuberculin Screening Questionnaire

Date: _____ Name _____ SS# _____

D.O.B. _____ Campus _____ Position _____

Address _____ Phone _____

SIGNS AND SYMPTOMS*

- 1. No Yes Night sweats
- 2. No Yes Productive cough for greater than two weeks
- 3. No Yes Loss of more than 10 lbs. of body weight in last 3 months without diet
- 4. No Yes Low grade, persistent night fever for 2 weeks or more
- 5. No Yes Chills or flu-like symptoms lasting 2 weeks or more

EMPLOYEE HISTORY*

- 1. No Yes Has the employee ever had a TB test before?

Approximate date: _____ Clinic: _____ Induration: _____

- 2. No Yes Has the employee ever had a chest x-ray for TB?

Clinic: _____ Last CXR: _____ Result: _____

- 3. No Yes Has the employee ever received (preventative) therapy for TB?

Clinic: _____

- 4. No Yes Therapy completed? Physician _____

- 5. No Yes Has the employee had visitors from out of the country?

- 6. No Yes Has anyone lived in the household who has been in prison?

I understand the definitions of the above-mentioned signs and symptoms, and if I have any of these signs or symptoms, I will report them to my physician and/or supervisor within one week. The information on previous TB test(s) are true to the best of my knowledge, and a consent form for a complete TB history has been filed.

UISD Employee Signature

Date

I have reviewed the signs and symptoms of tuberculosis with the above employee and have stressed the importance of reporting to the campus nurse within one week if two or more signs and symptoms are present.

COMMENTS _____

Campus Nurse/Dir. of School Health Programs

Date

* Based on the Laredo Health Department's Tuberculosis Elimination Program TB Screening Form

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