Orange County/Long Beach Consortium for Nursing

Patient's Name (print): _____ **Date:** _____

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 complete 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)	☐	☐
Loss of appetite for >2 weeks	☐	☐
Bloody sputum	☐	☐
Night sweats/fever	☐	☐
Unusual fatigue for > 2 weeks	☐	☐
Persistent cough > 2 weeks	☐	☐

Answering "yes" to any of the above questions constitutes a positive screening evaluation and requires further follow-up with 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**_____