STUDENT HEALTH SERVICES
UNIVERSITY OF THE PACIFIC

Student Name: _____
Student ID #: _____
Phone #: _____

# Tuberculosis Screening Questionnaire

Have you:

1. Ever had a positive TB test? ☐ Yes ☐ No
   a. If yes, have a chest x-ray performed within 6 months of matriculation.
   b. If no, skip to question #4.
2. Ever had a BCG vaccine? *attach documentation* ☐ Yes ☐ No
3. Ever been treated with INH? *attach documentation* ☐ Yes ☐ No
   a. If yes, dates given: _____
4. Had any vaccinations administered in the past 4 weeks? ☐ Yes ☐ No
5. Had any chronic or recurrent symptoms *lasting 3 weeks or longer*:
   a. Productive cough or spit up blood? ☐ Yes ☐ No
   b. Unexplained or recurrent fever, chills or night sweats? ☐ Yes ☐ No
   c. Unexplained fatigue? ☐ Yes ☐ No
   d. Chest pain? ☐ Yes ☐ No
   e. Unexpected weight loss or loss of appetite? ☐ Yes ☐ No
6. Had a health practitioner tell you that your immune system is suppressed? ☐ Yes ☐ No
7. Traveled overseas for more than 2 weeks in the last 12 months? ☐ Yes ☐ No
8. Been exposed to a family, volunteer and/or employee of high-risk congregate settings to TB in the last 12 month? (Ex: correctional facilities, long-term care facilities, homeless shelter) ☐ Yes ☐ No

**Explain *Yes* answers** _____
_____

☐ ***I declare that my answers/statements are correctly recorded, complete and true to the best of my knowledge.***

**Student Signature** _____ **Date:** _____

**PPD Skin Tests:** (No history of positive PPD result/disease)

| | Admin Date | Site | Admin Name/title | Read Date | mm Induration | Neg/Pos | Read Name/title |
|---|---|---|---|---|---|---|---|
| **PPD #1** | | LFA/RFA | | | | | |
| **PPD #2** | | LFA/RFA | | | | | |

**Note:** *PPD#2 must be administered 1-3 weeks apart from first placement. If each test is not read within 48-72 hours, then test/s must be repeated.*

**Chest X-ray:** (History of positive PPD skin test) *attach radiology report*:

Date: _____/ _____/ _____ ☐ Positive ☐ Negative

**Quantiferon Gold/TSpot:** *attach laboratory result*

*Note: Result not acceptable for students in Pharmacy and Physician Assistant Programs.*

Date: _____/_____/_____ ☐ Positive ☐ Negative

***Medical Facility Stamp:***

**Sumbit documentation**: Medical Portal (go.pacific.edu/myhealth)>Downloadable Forms Tab>Additional Immunization Records Category