University of Nebraska Medical Center

Confidential TB History and Symptom Review Form

Please Print

Students Full Name	Date of Birth	College and Year (ex: Med 3)

TB HISTORY

1.	Have you ever had a POSITIVE TB Screening	☐ Yes	☐ No
2.	Country of Birth_____		
3.	Did you receive BCG as a child	☐ Yes	☐ No
4.	Have you ever been prescribed INH Treatment	☐ Yes	☐ No
5.	Do you have diabetes, HIV, or another chronic condition that impairs you immune response	☐ Yes	☐ No
	If YES; Do you take immunosuppressive medication	☐ Yes	☐ No

Explain:_____

TB EXPOSURE RISK

1.	Since your last screening, have any of your; roommates, friends or family members been diagnosed with active Tuberculosis?	☐ Yes	☐ No
2.	Since your last screening have, you cared for a TB patient without wearing a N95 mask?	☐ Yes	☐ No
3.	Since your last screening have, you traveled outside of the United States?	☐ Yes	☐ No

If yes, Where?_____

TB SYMPTOM REVIEW

Since your last screening, have you experienced any of the following?

4.	Cough or chest pain that lasted longer than 3 weeks	☐ Yes	☐ No
5.	Fever that lasted longer than 3 weeks	☐ Yes	☐ No
6.	Coughing up blood	☐ Yes	☐ No
7.	Excessive sweating at night	☐ Yes	☐ No
8.	Unexplained weight loss	☐ Yes	☐ No
9.	Unexplained increase in weakness/fatigue	☐ Yes	☐ No

STUDENT SIGNATURE	Date	**PHYSICIAN'S SIGNATURE**	Date

Return Form To:

UNMC Student Health Administration Office, 983075 Nebraska Medical Center, Omaha, NE 68198-3075
Tel: 402-559-5158 OR 402-559-5691 Fax: 402-559-8118

Revised 01/31/2017 ck