University of Nebraska Medical Center

Tuberculosis Symptom Review Form

To be completed by the student

Please print

Name: _____ Date of birth: _____ College and Year (e.g. Med 3): _____

TB History

1. Have you ever had a POSITIVE TB screening? ☐ Yes ☐ No
2. What is your 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 your immune system? ☐ 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 an 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:

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

_____ _____ _____ _____

Student's signature Date Physician's signature Date

Attach all supporting documentation. You will need to submit this information via your MyRecords Immunication Center.

For questions, please contact UNMC Student Health at studenthealth@unmc.edu or call us at (402) 559-5158