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

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