TUBERCULOSIS SCREENING
History of Positive TB Skin Test

Employee/Student Health and Wellness
Division of Infectious Disease and International Medicine
College of Medicine
813-974-3163

Please complete the following information if you have a History of a Positive TB skin test:

EMPLOYEE / STUDENT / FACULTY INFORMATION: **DATE:**

Last Name: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ **First Name**: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Please print! *Please print!*

College/School: ☐ Medicine ☐ Nursing ☐ Public Health ☐ Physical Therapy ☐ Medical Clinics ☐ Other:_____________

Department/Unit/Zone: ________________________

Cell Phone:________________ **Home Phone:**________________

Work Phone: ______________________________ **Mail Code**: ________________ **Fax**: __________________

Email Address:____________________

Position: ☐ MD ☐ DO ☐ ARNP ☐ PA ☐ Resident / Fellow: PGY____
☐RN ☐ LPN ☐MA ☐ Student ☐ Other:____________________

Have you ever received BCG? ☐No ☐ Yes → If YES, date of BCG: ______________________

Date of last PPD skin test: ______________________

Did you take any medication associated with the positive TB skin test? ☐No ☐Yes → Dates: ___________
What medication(s) did you take?

Please check (√) your response for any of the following **unexplained symptoms**:

1. Unexplained fatigue ☐ Yes ☐ No
2. Unexplained weight loss ☐ Yes ☐ No
3. Loss of appetite ☐ Yes ☐ No
4. Fever (usually at night) ☐ Yes ☐ No
5. Night sweats (drenching) ☐ Yes ☐ No
6. Persistent cough (>2 weeks) ☐ Yes ☐ No
7. Spitting/coughing up blood ☐ Yes ☐ No
8. Pain in chest ☐ Yes ☐ No

Date of last chest x-ray: ________________ Results:______________________