Evergreen Valley College Student Health Center

3095 Yerba Buena Road, San Jose, CA 95135 ◊ Office # 408-270-6480; Fax # 408-532-1831

TB Symptom Review

Last Name: _____ First Name: _____ DOB: _____

□ Student ID Number: _____ □ Employee ID Number: _____

1. Yes □ No □ Do you have a medical illness which is currently infectious or would prevent you from performing your assigned duties at this time? If "yes" please describe: _____
2. Yes □ No □ Have you had an unexplained weight loss in the last year? If "yes" How much?_____
3. Yes □ No □ Do you have a persistent cough lasting 3 weeks or more?
4. Yes □ No □ Do you cough up blood?
5. Yes □ No □ Do you have persistent unexplained fevers or night sweats?
6. Yes □ No □ Have you seen a doctor for any of the symptoms above? If "yes" which numbered item? ___
7. Yes □ No □ Have you been given a TB Skin Test previously? Date: _____ Result: _____

ANSWER QUESTIONS 8-10 ONLY IF YOU HAVE HAD A PRIOR POSITIVE TB TEST.

8. Where were you born? Country_____State/Province_____
   a. If foreign born, how old were you when you moved to the United States? _____
   b. Yes □ No □ Have you ever been vaccinated with BCG? At what age? ____ How many times? ____
9. Yes □ No □ Did you have a chest x-ray? Date: _____ Result: _____
10. Yes □ No □ Did you take any medication for Latent Tuberculosis?
    Name of medication: _____ How long did you take it for? _____
11. Yes □ No □ Do you have any medical conditions that may suppress your immune system?
    (If your immune system is weakened by illness, you have an increased risk of developing active Tuberculosis and therefore require closer monitoring and follow up.)

Patient Signature: _____ Date: _____

Date PPD Placed: _____ Date PPD Read: _____ PPD Result: _____

Date of Chest X-ray: _____ Chest X-ray Results: _____

□ Asymptomatic Clearance
□ Referred for Repeat Chest X-ray
□ Referred to Santa Clara County TB Clinic for Follow-up

Health Provider Name: _____ Health Provider Signature: _____ Date: _____