

**University Health Services  
Mandatory Annual Tuberculosis Screen  
History of a Positive TST(PPD)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Department: \_\_\_\_\_ Extension: \_\_\_\_\_

In what year did you first have a positive reaction to the TB skin test? \_\_\_\_\_

Have you ever received the BCG vaccine? Yes No  
If yes, approximately when? \_\_\_\_\_

Date/location of most recent chest x-ray: \_\_\_\_\_

Results: \_\_\_\_\_

Treatment with Isoniazid? Yes No  
Duration/Dates: \_\_\_\_\_

Do you have any of the following:

	Yes	No	If yes, when did it start?
Persistent cough?	Yes	No	_____
Sputum?	Yes	No	_____
Unexplained			
Weight Loss?	Yes	No	_____
Prolonged Fevers?	Yes	No	_____
Night Sweats?	Yes	No	_____
Undue Fatigue?	Yes	No	_____
Tobacco History?	Yes	No	_____
Current Smoker?	Yes	No	___ packs per day
Cigars/Pipes?	Yes	No	How much: _____
Current steroid use?	Yes	No	Dose: _____
Current lung d/o?	Yes	No	_____

\_\_\_\_\_  
Employee Signature Date

\_\_\_\_\_  
UHS Reviewer Signature Date

