Harriet Rothkopf Heilbrunn
School of Nursing

TUBERCULOSIS SCREEN

To be completed annually by individuals who have shown documented proof of receiving BCG vaccine or a positive PPD or are submitting one of the following: chest x-ray, Quantiferon gold blood test, t-spot blood test.

Name: ____

PPD History: ____

1. Do you have or have you had any of the following?

	Yes	No
Chronic Renal Failure		
Immunosuppression		
Diabetes Mellitus		
Blood/lymph disease i.e. Leukemia, Hodgkins, Cancer		
Silicosis		
Gastrectomy		
Jejunoileal Bypass		

2. Do you take corticosteroids (prednisone, cortisone)? ____ Yes ____No
   If "yes", please explain ____

3. Are you taking any immunosuppressive drugs? ____ Yes ____ No
   (i.e. Azathioprine, cyclosporine, muromonab)
   If "yes", please explain ____

4. Do you have any of the following symptoms? If "yes", please explain.

	Yes	No	Comments
Fever (unexplained, persisting more than two weeks)			
Night Sweats (for more than two weeks)			
Unexplained weight loss (5 lbs)			
Cough (persisting longer than 3 weeks)			
Blood-tinged phlegm (anytime)			

If I develop any of the above symptoms during the course of the academic year, I will notify the Clinical Site Coordinator.

Signature: __________________________________

Date: ___________