Northeast Ohio
MEDICAL UNIVERSITY

Annual TB Signs & Symptoms Screening Checklist

Fill out if you have had a positive TB test in the past

Name _____ Date _____/_____/_____

DOB _____/_____/_____ St ID # _____Phone _____

Date of Positive TB Test: _____ Result: _____mm

Date of Positive QuantiFERON Test: _____ Result: _____

Date of Last Chest X-Ray: _____ Positive for TB _____ Negative for TB _____

Are you currently or have you in the past year experienced any of the following symptoms?
Circle "Yes" or "No"

Yes	No	A persistent cough that has lasted longer than 3 weeks
Yes	No	Coughing up blood or sputum
Yes	No	Night Sweats
Yes	No	Shortness of breath
Yes	No	Unexplained weight loss
Yes	No	Decrease in appetite
Yes	No	Extreme fatigue/tiredness

Please indicate any other signs or symptoms you may have experienced or are currently experiencing:

_____

_____

_____

I understand it is my responsibility to report the onset of signs and symptoms of tuberculosis to my Primary Care Physician and to notify NEOMED.

_____ _____

Signature Date