STCC
Springfield Technical Community College

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Health and Wellness Center · Building 19, Room 177 · Phone (413) 755-4230 · Fax (413) 755-6045

Positive Tuberculosis Screening Questionnaire

Name: _____ Date: _____
(last) (first) (middle)

Address: _____
(Street address) (Apartment Number) (City) (State) (Zip code)

Telephone: _____ Date of Birth: _____ Student ID #: _____

Type of Evaluation: ☐ Initial ☐ Annual ☐ Post Exposure

Date of First Positive TB test: _____	Type of Test: _____ (Mantoux, Tine)	Degree of reaction: _____ (millimeters) ☐ Unknown

Have you ever received BCG: (Tuberculosis vaccine)?	☐ No ☐ Yes ☐ Unknown	If yes, when, where?	Have you ever had an abnormal chest x-ray?	☐ No ☐ Yes ☐ Unknown	If Yes, when, where?
Have you ever been treated with medicine for Tuberculosis?	☐ No ☐ Yes ☐ Unknown		If yes, did you take all of the medication?	☐ No ☐ Yes ☐ Unknown	What type, dosage, duration?

Country of birth: ☐ U.S.A. ☐ Other_____	Date of entry to U.S.A.	Have you been in close contact with anyone who was recently diagnosed with Tuberculosis?	☐ No ☐ Yes	If yes, Who?

Extensive travel or living outside the USA within past 5 years?	☐ No ☐ Yes	If yes, where?

Medical History:

☐ Insulin-dependent Diabetic	☐ Steroid Therapy	☐ Cancer of head, neck, lung
☐ Kidney disease	☐ Silicosis	☐ Leukemia, Lymphoma, or blood disorder
☐ Stomach/intestinal surgery	☐ Organ Transplant	☐ Immunodeficiency or HIV disease

Do you have any of the following symptoms:

Chronic cough?	☐ No ☐ Yes	If yes, frequency?	Productive cough?	☐ No ☐ Yes	If yes, color of sputum?
Persistent night sweats?	☐ No ☐ Yes	If yes, how often?	Chronic fatigue?	☐ No ☐ Yes	If yes, duration:
Loss of appetite?	☐ No ☐ Yes		Involuntary weight loss?	☐ No ☐ Yes	If yes, how much?

Signature of patient: _____ (date)

Evaluator's comments: (To be completed by STCC Health Services Department.)

Annual review	☐ No ☐ Yes		Chest x-ray	☐ No ☐ Yes	If yes, date and result.
Referral for further eval.	☐ No ☐ Yes	If yes, describe.			

Signature of evaluator: _____ (date)