

↓↓↓ Annual TB Questionnaire – ONLY for history of TB and/or positive TB test ↓↓↓

This form is **only** to be completed by student and provider if student has a history of TB or if any current TB test (blood test or PPD) is positive. In addition to this questionnaire, student must submit most recent chest x-ray (dated within 12 months).

If student does not have a history of TB or a current positive TB test, completion and submission of this form will not lead to compliance. Please refer to checklist on page 1 of this packet and/or module 4 of the Compliance Overview Training Video Series for your program, available at <http://ocpc.office.uconn.edu/students>.

Student Questionnaire

Have you experienced any of the following symptoms in the past year? Please indicate yes or no for each item.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Persistent productive cough? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Coughing up blood? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Chest pain? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Shortness of breath / difficulty breathing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Unexplained fever lasting more than 3 days? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Unexplained night sweats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Unexplained sudden weight loss? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Unexplained fatigue / run down feeling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Unexplained swollen lymph nodes or masses in your armpit or neck area? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Student Attestation

The information presented above is true and accurate to the best of my knowledge.

Student Signature: _____ Date: ___/___/___

Student Name (printed): _____

Provider Attestation

Please select one:

- I certify that no treatment is currently recommended for this student.
- I certify this student is currently undergoing treatment for LTBI and that said treatment should be completed by _____ (specify date).
- I certify that this student has completed all recommended treatment.

Provider Signature: _____ Date: ___/___/___ Phone: _____

Provider Name (printed): _____ Address/Stamp: _____

Provider Type: MD DO APRN PA _____

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