

Tuberculosis (TB) Risk Assessment Questionnaire

Last Name _____	First Name _____	MI ____	Student ID# _____
Address _____	City _____	State _____	Zip _____
Phone _____	Date of Birth _____	Email Address _____	

1. **Are you from or have you lived for two months or more in Africa, Asia, Central or South America, or Eastern Europe?** No Yes If yes, list countries _____

2. **Have you been diagnosed with a chronic condition that may impair your immune system?**
 No Yes If yes, check all that apply

<input type="checkbox"/> Chronic steroid use	<input type="checkbox"/> Gastrectomy/intestinal bypass	<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> HIV infection	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Dialysis/Renal failure
<input type="checkbox"/> Cancer of the head or neck	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Chronic malabsorption syndromes
<input type="checkbox"/> Silicosis	<input type="checkbox"/> Use of TNF- α antagonist	<input type="checkbox"/> Low body weight (10% or more below ideal)
<input type="checkbox"/> Leukemia, lymphoma or Hodgkin's disease	<input type="checkbox"/> Other _____	

3. **Have you ever resided, worked or volunteered in any of the following facilities?**
 No Yes If yes, check all that apply

<input type="checkbox"/> Prison	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing home
<input type="checkbox"/> Homeless shelter	<input type="checkbox"/> Other long term treatment center _____	

4. **Do you currently have any of the following symptoms?**
 No Yes If yes, check all that apply

<input type="checkbox"/> Cough \geq 3 weeks	<input type="checkbox"/> Unexplained fever	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Chills
<input type="checkbox"/> Productive cough (coughing up something)	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Respiratory difficulty (shortness of breath)	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weakness

5. **Have you ever had contact with a person known to have active tuberculosis?**
 No Yes

6. **Have you ever used injection drugs?**
 No Yes

7. **Have you had a tuberculin skin test before?**
 No Yes If yes, list where given _____ Date ____/____/____ (attach results)

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

 Signature of Student or Guardian

 Date