

University Health Services  
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**TB Symptom Checklist**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Department: \_\_\_\_\_ DOB: \_\_\_\_\_

**In the last month, have you had any of the following symptoms?**

Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cough (for >3 weeks)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chills	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Weight Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Night Sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sputum Production	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood in Sputum	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Explain all "Yes" answers:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last PPD Skin Test? \_\_\_\_\_ What were the results? \_\_\_\_\_

When was your last Quantiferon/T-Spot test? \_\_\_\_\_ What were the results? \_\_\_\_\_

Have you received BCG (vaccine for Tuberculosis)? Yes  No

If yes, where and when \_\_\_\_\_

If you have had a positive skin test, answer the following: Date: \_\_\_\_\_

Chest X-ray Date \_\_\_\_\_ Results \_\_\_\_\_

Treatment with INH: Yes  No  Dates: \_\_\_\_\_

<b>Risk Factor</b>	<b>Yes</b>	<b>No</b>
Recent close contact with someone with infectious TB disease		
Foreign-born in (or significant travel to) high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Latin America)		
Fibrotic changes on chest x-ray suggesting inactive or past TB disease		
HIV/AIDS		
Organ transplant recipient		
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF- $\alpha$ antagonist)		
History of illicit drug use		
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, cancer of the head or neck, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]		

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
UHS staff signature  
03/26/2013/uhs

\_\_\_\_\_  
Date reviewed