Sacred Heart University TB History and Symptoms Questionnaire

Submit completed form and any supporting documents by uploading to the Student Health Portal – https://myhealth.sacredheart.edu/login_directory.aspx

Student Last Name	**Student First Name**	**Student Middle Name**
Date of Birth	**Gender Identity**	**US Cell Phone #**
Country of Birth	**Year of US Entry (if born outside of US)**	**SHU ID#**

TUBERCULOSIS (TB) HISTORY Please answer the following questions:	
1. Date of positive TB screening test: Please provide the month, day and year:	MM / DD / YYYY
2. Please check the type of TB test performed that was positive:	☐ PPD (skin test) ☐ Quantiferon Gold (blood test) ☐ T-spot (blood test)
3. When was your last chest x-ray performed? Please provide the month, day and year:	MM / DD / YYYY
4. Have you ever been told that you have active TB disease?	☐ Yes ☐ No
5. Have you ever lived with anyone with active TB disease?	☐ Yes ☐ No
6. Did you ever receive the BCG vaccine?	☐ Yes ☐ No
7. Have you spent more than 1 month living in a foreign country (outside of the US) in the past 2 years? If yes, please write the name(s) of the country:	☐ Yes ☐ No
8. Were you ever treated with medication for active or latent (inactive) TB disease? If yes, please provide the following information: Name of Medication(s): Dates of treatment:	☐ Yes ☐ No
9. Do you have a medical condition that suppresses your immune system, or are you taking immunosuppressive medications to treat a chronic disease or organ transplant? (Examples of medications would be Remicade, Humira, Enbrel, or high doses of steroids)	☐ Yes ☐ No

TUBERCULOSIS (TB) SYMPTOMS QUESTIONNAIRE Have you recently had (in the past 2 months) or currently have any of the following?	
1. A productive cough lasting more than 3 weeks?	☐ Yes ☐ No
2. Cough productive of blood?	☐ Yes ☐ No
3. Unexplained weight loss?	☐ Yes ☐ No
4. Unexplained loss of appetite?	☐ Yes ☐ No
5. Fever, chills or night sweats for no known reason?	☐ Yes ☐ No
6. Shortness of breath?	☐ Yes ☐ No
7. Chest pain?	☐ Yes ☐ No
8. Increased fatigue?	☐ Yes ☐ No

I confirm that the above information is accurate.

Student Signature	**Date**
X	