## Stevenson University Wellness Center

## Students with Positive TST

Please complete the following questionnaire: Name: Address: \_\_\_\_\_ City Zip Code State Street Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Major: \_\_\_\_\_ Symptoms: Night Sweats Yes No Weight/ Appetite loss Yes No Cough Yes No Yes No Phlegm Chest Pains Yes No Shortness of Breath Yes No Recurrent Fevers Yes No Date of First Positive TST \_\_\_\_\_ Date of latest Chest X-Ray \_\_\_\_\_ Normal \_\_\_\_ Abnormal \_\_\_\_ Have you taken Prophylactic TB medication? Yes No If yes, name of medication \_\_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Comments: \_\_\_\_\_ To be completed by healthcare provider: \_\_\_\_ No symptoms of active TB \_\_\_\_ Patient sent for Chest X-Ray \_\_\_\_ Patient referred to private physician/PCP Patient referred to Health Department Healthcare Provider Signature and Title Date

Updated 3/23/09

Print Name and Title