UTSW Student Health Services
TUBERCULOSIS SCREENING 2015

Name: Date of Birth:
Phone: Email:
Educational Program: Level:

History of Positive TB Test

Date and type of positive test (e.g., QFT, PPD):
Date and result of chest x-ray:
Did you take medications for TB? Yes No
If yes, what medications:
Start Date: End Date:
Were you born outside the United States? Yes No

Symptom Survey:

In the past year have you had:

- A known exposure to active TB Yes No
- A persistent cough lasting longer than 2 weeks Yes No
- Unintentional weight loss/prolonged loss of appetite Yes No
- Profuse night sweats Yes No
- Hemoptysis (coughing up blood) Yes No
- Unexplained chills\fever Yes No

Note: Student Health Services does not require annual chest x-rays.

Please bring or fax (214-645-8676) the completed and signed form to Student Health Services (8th floor Aston)

SIGNATURE: _____Date: _____

5323 Harry Hines Blvd. / Dallas, Texas 75390-8861 / 214-645-8690 Telefax 214-645-8676