Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210

Last	First	MI
ID#	(Place patient label here)	

ANNUAL TUBERCULOSIS EVALUATION

You have had a reported history of a positive tuberculosis test. Please answer the following questions related to pulmonary symptoms suggestive of tuberculosis (TB). This form must be returned to Student Life Student Health Services Preventive Medicine department.

1. Have you had contact in the past year with any person who had active TB disease?

   Yes No

2. Have you experienced any of the following symptoms during this past year?

(1) persistent cough	Yes	No
(2) cough producing bloody sputum	Yes	No
(3) prolonged fever, chills	Yes	No
(4) night sweats	Yes	No
(5) prolonged fatigue	Yes	No
(6) unexplained weight loss/loss of appetite	Yes	No

3. Do you have any of the following?

(1) history of active TB infection	Yes	No
(2) diabetes	Yes	No
(3) chronic lung or kidney disease	Yes	No
(4) chronic peptic ulcer or stomach surgery	Yes	No
(5) condition causing reduced immunity	Yes	No
(6) condition requiring prolonged use of steroids or immunosuppressive medications	Yes	No

If you answered YES to any of the above, please name the healthcare provider you consulted. What was the diagnosis and treatment?

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You should be aware of the signs and symptoms of active TB disease listed above (question 2) and seek prompt medical evaluation if any of these symptoms develop.

Printed Name______________________ Date of Birth__________

Student Signature______________________ Date__________