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 TB skin test. Please answer the following questions related to pulmonary symptoms suggestive of tuberculosis. This form must be returned to SHS Preventive Medicine.

1. Have you had contact in the past year with any person who had active tuberculosis 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_____