INDIANAPOLIS
CAMPUS HEALTH

TUBERCULOSIS SYMPTOM AND RISK ASSESSMENT QUESTIONNAIRE

PLEASE PRINT LEGIBLY

Name: _____ Date of Birth: _____

Status: Faculty Staff Student Department / School: _____

Employer (circle all that apply): IU IU Health IU Health Physicians Other: _____

HISTORY

In the past year, have you			
1.	Had any unexplained fever in recent weeks to months?	Y	N
2.	Had any drenching sweats in recent weeks to months?	Y	N
3.	Had any unexplained coughs in recent weeks to months?	Y	N
4.	Had any chest pain in recent weeks to months?	Y	N
5.	Had any unexplained weight loss in recent weeks to months?	Y	N
6.	Had any known exposure to TB? If YES, when?	Y	N
7.	Had an abnormal chest x-ray in the past?	Y	N
8.	Provided medical care to others in a country with endemic TB since your last TB test?	Y	N
9.	Had a history of immunosuppression, such as an organ transplant, taking immunosuppressive medications or HIV?	Y	N
10.	Been on more than 15mg of prednisone of more than one month?	Y	N
11.	Moved to the United Stated within the last five years? If so, where did you live previously?	Y	N
12.	Had a history of any of the following: IV drug use, working in a mycobacteriology laboratory, or working as a resident / employee of a high risk setting (e.g. hospital)?	Y	N
13.	Had any of the following medical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemia, lymphoma, head or neck cancer, lung cancer, stomach or intestinal surgery or weight loss of more than 10% below ideal body weight?	Y	N

IF HISTORY OF POSITIVE TB TEST

1. When did you first convert to a + TB skin test or blood test (IGRA)? _____
2. Did you ever receive treatment for TB? ☐ Yes ☐ No If yes, how long? _____
   What medications? _____
3. Who followed up your conversion? _____
4. When was your last chest x-ray? _____ Results? _____

_____ _____
Date Signature

_____ _____
Date Reviewed by: (IU Indianapolis CH Staff)

Determination *(Circle One)*: Asymptomatic / Symptomatic