Stevenson University
Wellness Center

# Students with Positive TST

Please complete the following questionnaire:

Name: _____
Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____
Major: _____

Symptoms:

| | | |
|---|---|---|
| Night Sweats | Yes | No |
| Weight/ Appetite loss | Yes | No |
| Cough | Yes | No |
| Phlegm | Yes | No |
| 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

_____
Print Name and Title

Updated 3/23/09