Please email this form to **UMHealthOffice@miami.edu**

University of Miami | Employee Health Office | MEDICAL STUDENT TB Screening Questionnaire

First Name: _____ Last Name: _____C#: _____

Home Address: _____ City: _____State:_____ Zip: _____

Date of Birth: _____ Job Title/Occupation: _MEDICAL STUDENT_____ Graduation YEAR:_____

Phone number: _____ Dept Name: __Student Affairs____Building/Room #: RMSB 2155_____

☐ **Faculty** ☐ **Full time** ☐ **Temporary** ☐ **Part time** **XXX Student** ☐ **Volunteer** ☐ **Contract** ☐ **Visitor**

	Answer Yes or No to the following questions	***Yes***	***No***
1.	PPD allergy?	☐	☐
2.	Any allergies? ***If YES, to what?***	☐	☐
3.	Do you have a history of a positive TB skin test or blood work for TB?	☐	☐
4.	Were you ever diagnosed with TB? ***If YES, when?***	☐	☐
5.	Have you ever taken medications for TB? ***If YES, when?***	☐	☐
6.	BCG is a vaccine for TB. Were you BCG vaccinated?	☐	☐
7.	Do you have direct contact with patients?	☐	☐
8.	Do you have a weak immune system	☐	☐
9.	Are you being treated with steroids, corticosteroids or immunosuppressive agents?	☐	☐
10.	TB skin test or blood work for TB in the past 12 months? ***If YES, where?***	☐	☐
11.	Chest x-ray in the past 6-12 months? ***If YES, where?***	☐	☐
12.	Have you ever had lung disease?	☐	☐
13.	Do you have animal contact at work ***or*** enter animal care areas? ***If YES, name of species:***	☐	☐
14.	Productive, prolonged cough (greater than 2 weeks)?	☐	☐
15.	Chest pain?	☐	☐
16.	Coughing up blood?	☐	☐
17.	Fever that persists?	☐	☐
18.	Frequent chills?	☐	☐
19.	Night sweats?	☐	☐
20.	Frequent fatigue?	☐	☐
21.	Unexplained loss of appetite?	☐	☐
22.	Unexplained weight loss?	☐	☐

If YES to any of the above questions, please provide explanation.

_____

_____ _____

23. Medical Student - Print Name **Date**

STOP HERE: Office Use ONLY below

Date PLACED: _____ **PLACED by:** _____ ☐ **RFA** ☐**LFA**

Lot#_____**Manufacturer**_____**Exp Date**_____ ☐ **Dose (0.1 ml)** ☐ **Intradermally**

Date READ: _____ **READ by:** _____

Results ☐ **NEG** ☐ **POS** **Size of Induration**_____ **MM -CXR ordered?** ☐**YES** ☐**NO** **If POSITIVE, conversion?** ☐**Yes** ☐**No**

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Website: www.miami.edu/employee-health | Office**:** (305) 243-3267 | **Fax**: (305) 243-2393