

Date: _____

TB Assessment for Positive TST's

Name (Print): _____ DOB: _____ PID: _____

Have you ever had a positive TB skin test? **Yes** **No**

Have you had a chest x-ray as a result of a positive TB skin test? **Yes** **No**

If "Yes" - Year taken: _____ Result: **Normal** **Abnormal**

Have you **recently** had any of the following symptoms for **unknown** reasons?

- | | | | | | |
|------------------------------------|-------------------------------------|------------------------------------|--------------------------------|-------------------------------------|------------------------------------|
| A cough longer than 3 weeks | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Unexplained weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coughing up blood | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loss of Appetite | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Urinary Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Night Sweats | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fatigue | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

 Patient Signature

If you have had a positive tuberculin skin test in the past followed by a normal chest x-ray and have remained asymptomatic, no further action is necessary at this time. A health assessment should be documented annually.

Student Health Services
 Colorado State University-Pueblo