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COLLEGE OF MARIN

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Symptom Checklist for Tuberculosis

PLEASE COMPLETE THIS SECTION

Name _____ Occupation _____

Have you ever been sick with TB? ☐ yes ☐ no

When was your first positive TB test? Date _____

Have you ever taken any TB medication? ☐ yes ☐ no

If yes, dates:_____ duration: _____ location:_____

What kind of medication taken? _____

PLEASE COMPLETE THIS SECTION

Do you feel tired all the time? ☐ yes ☐ no
Do you have a lack of appetite? ☐ yes ☐ no
Have you had an unexpected weight loss? ☐ yes ☐ no
Do you have a recurring fever? ☐ yes ☐ no
Do you have a persistent fever? ☐ yes ☐ no
Do you have night sweats or chills? ☐ yes ☐ no
Do you have blood in your sputum? ☐ yes ☐ no
Have you had contact with a person with active TB since your last screening? ☐ yes ☐ no
Do you have an immune disorder? ☐ yes ☐ no

If yes, specify: _____

Have you traveled outside the U.S. since your last screening? ☐ yes ☐ no

If yes, specify _____

Completed by: _____ Date: _____

Disclaimer: This document is provided solely for reference purposes. Covered Entities under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

PHYSICIAN ONLY

Date of last chest x-ray: _____ Results of chest x-ray: ☐ negative ☐ positive

Repeat CXR needed: ☐ yes Reason for repeat: ☐ high risk ☐ positive symptoms ☐ last x-ray over 10 years
☐ no

☐ This person is free of active Tuberculosis and may continue to have contact with other people in work, school, or service-related activities

☐ Further follow-up is needed prior to clearance.

Recommendations: ☐ Repeat TB evaluation in 1 year, **OR** _____

Comments:

Physician's signature _____ Date_____

Staff only

☐ Signed clearance sent to personnel by _____