

Name: _____
Date of Birth: _____
If Student: APID _____
College _____
If Employee: ZPID _____
Department _____

Occupational Health

Initial TB Symptom Review

Today's Date: _____

1. Have you lost weight in the last 6 months without dieting? Yes No
If yes, how much? _____
2. Do you on a regular basis have night sweats or wake up with the sheets wet from sweating? Yes No
If yes, how long? _____
3. Do you have a frequent persistent cough? Yes No
4. Are you bothered by being tired all the time? Yes No
If yes, how long? _____
5. Are you bothered by shortness of breath? Yes No
If yes, how long? _____
6. Do you cough up blood? Yes No
If yes, how long? _____
7. Have you been having increased temperature? Yes No
If yes, how long? _____

Approximate Date of reactive PPD: _____

Did you have a chest x-ray done after the reactive PPD? Yes No
If yes, what were the results? _____

Did you take medication after the reactive PPD? Yes No
If yes, what medicine and for how long? _____

Please return completed form to:
MSU Occupational Health
347 Olin Health Center
East Lansing, MI 48824-1037
or fax to 517.355.0332

Review: Negative Positive Reviewed by: _____ Date _____