



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

Occupational Health

Initial TB Symptom Review

This form is **ONLY** for those with previously reactive TB tests.

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? _____

Were you counseled regarding latent TB? Yes No
 If yes, where? _____

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

Please return this completed form, along with documentation of your previously positive TB test, chest x-ray report, and proof of counseling to:

**MSU Occupational Health
 346 Olin Health Center,
 East Lansing, MI 48824-1037
 or fax to 517.355.0332**

Do NOT write below this line

Review: Negative Positive Reviewed by: _____ Date _____