



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

Occupational Health

Annual TB Symptom Review

This form is ONLY for those with previously reactive TB tests who have already completed the Initial 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? _____

Please return this completed form 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 _____