

Occupational Health

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

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? If yes, how much?	Yes 🗌	No 🗌	
2.	Do you on a regular basis have night sweats or wake up with the sheets wet from sweating? If yes, how long?	Yes □	No	
3.	Do you have a frequent persistent cough?	Yes □	No 🗌	
4.	Are you bothered by being tired all the time? If yes, how long?	Yes 🗌	No 🗌	
5.	Are you bothered by shortness of breath? If yes, how long?	Yes 🗌	No 🗌	
6.	Do you cough up blood? If yes, how long?	Yes 🗌	No 🗌	
7.	Have you been having increased temperature? If yes, how long?	Yes 🗌	No 🗌	
Appro	ximate Date of reactive PPD:	-		
Did you have a chest x-ray done after the reactive PPD? If yes, what were the results?		Yes 🗌	No 🗌	
Were you counseled regarding latent TB?		Yes 🗌	No 🗌	
If yes, where? Did you take medication after the reactive PPD? If yes, what medicine and for how long?		Yes 🗌	No 🗌	
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 Olin Health Center 463 E. Circle Drive, Room 123 East Lansing, MI 48824-1037 or fax to 517.355.0332				
Do NOT write below this line				
Revie	v: Negative Positive Reviewed by:	Dat	е	