

Stevenson University
Wellness Center

Students with Positive TST

Please complete the following questionnaire:

Name: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Major: _____

Symptoms:

Night Sweats	Yes	No
Weight/ Appetite loss	Yes	No
Cough	Yes	No
Phlegm	Yes	No
Chest Pains	Yes	No
Shortness of Breath	Yes	No
Recurrent Fevers	Yes	No

Date of First Positive TST _____

Date of latest Chest X-Ray _____ Normal _____ Abnormal _____

Have you taken Prophylactic TB medication? Yes No

If yes, name of medication _____ Dose _____ Duration _____

Comments: _____

To be completed by healthcare provider:

- ___ No symptoms of active TB
- ___ Patient sent for Chest X-Ray
- ___ Patient referred to private physician/PCP
- ___ Patient referred to Health Department

Healthcare Provider Signature and Title

Date

Print Name and Title