Northwest Missouri State University
University Wellness Center
800 University Drive
Maryville MO 64468
Phone 660-562-1348

Tuberculosis Screening

Name: ____ Date ____/____/____ 919__________________

☐Male ☐Female Date of Birth ____/____/____ Country of Origin ____________________________

Local Address ____ Phone _______________________

1) Have you EVER received a BCG vaccine, or known TB exposure? ☐Yes ☐No ☐Not Sure

2) Are you on steroids, chemotherapy, or HIV positive? ☐Yes ☐No

3) In the past 6 weeks, have you had; an MMR, polio, yellow fever, or varicella vaccine? ☐Yes ☐No

4) Do you currently have any of the following:
   - Productive cough ☐Yes ☐No
   - Bloody sputum ☐Yes ☐No
   - Weight loss ☐Yes ☐No
   - Night sweats ☐Yes ☐No
   - Unusual tiredness ☐Yes ☐No
   - Fever ☐Yes ☐No

** For Second PPD visit, have your answers regarding these symptoms changed?
☐Yes ☐No If Yes, How?_________

5) In the last 6 weeks have you been ill with measles, influenza, or mumps? ☐Yes ☐No

6) Have you ever had any previous TB skin testing? ☐Yes ☐No

7) Please list any medication allergies ____

8) Please list any current medications you are taking ____

Patient Signature ____ Date ____/____/____

♦♦

1st TST Date Given ____/____/____ By ____

☐Right Arm ☐Left Arm Manuf. Sanofi Pasteur Lot#__________ Exp Date ____/____/____

Date read ____/____/____ By ____

☐Negative ☐Positive __________________mm X ___________________mm

♦♦

2nd TST Date Given ____/____/____ By ____

☐Right Arm ☐Left Arm Manuf. Sanofi Pasteur Lot#__________ Exp Date ____/____/____

Date read ____/____/____ By ____

☐Negative ☐Positive __________________mm X ___________________mm

Blood Test Date Drawn ____/____/____ By ___________________________________

Results of Interferon Gamma Release Assay (IGRA) _______________________________