UNIVERSITY OF Cincinnati

TB Screening

Name_____ Date of Birth _____

M# _____ Telephone _____

City _____ Email _____

Country (Current) _____ Housing on Campus Yes ○ No ○

Country of Birth _____

	TB Screening (All answers are REQUIRED)					
1.	Do you have a history of a positive TB Skin Test?	○	Yes		○	No
2.	Do you have a history of having tuberculosis (TB)?	○	Yes		○	No
3.	Do you now have any condition requiring prolonged steroid or immunosuppressive therapy?	○	Yes		○	No
4.	Do you have immunosuppressive illness at the present time?	○	Yes		○	No
5.	Have you had any of the following in the past year?	○	Yes		○	No
	Recent, close contact with any person having active tuberculosis?	○	Yes		○	No
	Unexplained cough?	○	Yes		○	No
	Coughing up blood?	○	Yes		○	No
	Unexplained weight loss or increased fatigue?	○	Yes		○	No
	Unexplained fever or night sweats?	○	Yes		○	No
6.	Have you ever had the BCG vaccine?	○	Yes		○	No