Student Printed Name: ________________________________ Student ID Number: ________________________________

Date: ______________________

Craven Community College
Health Programs Learning Center
TB Surveillance Questionnaire
Initial/Annual

Please note that this questionnaire is for students who have identified themselves and/or presented documents that determine a documented positive TB test reaction or converter, and will be a part of the student medical record. *It is important that you furnish records of the initial conversion/reaction to the TB test and all treatments given, if any. Submit a report of any x-ray completed at the time of the treatment or since then as available. After this initial documentation, the Student Annual Questionnaire must be completed for subsequent annual TB surveillance. Please respond to the questions listed below and return as directed.

Are you having any of these symptoms?

1. Unplanned weight loss (more than 10 percent of body weight)?
   __Yes __No
2. Night sweats (that cause you to have to change the bed sheets)?
   __Yes __No
3. Chronic cough in absence of cold or flu (greater than 3 weeks)?
   __Yes __No
4. Coughing blood-streaked sputum?
   __Yes __No
5. Fever lasting several weeks?
   __Yes __No
6. Pain in chest when taking a breath?
   __Yes __No
7. Unusual tiredness or weakness lasting several weeks?
   __Yes __No
8. Have you been diagnosed with diabetes, silicosis, renal disease, or liver disease or said to be immunocompromised?
   __Yes __No
9. Have you been diagnosed with pneumonia during the past year?
   __Yes __No
10. Have you traveled outside of the United States within the past year since you were previously evaluated for signs/symptoms of tuberculosis?
    __Yes __No