Santa Clara University

Adult Tuberculosis (TB) Risk Assessment Questionnaire

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-1215550)

Full Name: _____

SCU ID Number: _____

SYMPTOMS

Welcome. Please answer all of the following questions. The information you give is confidential. It will help us to understand and evaluate your situation.

Are you currently or have you had any of the following symptoms with in the last 12 months?	YES	NO
Cough lasting longer than 3 weeks?		
Coughing up blood		
Fever		
Weight Loss		
Night Sweats		
Excessive fatigue		
If the answer is "YES" to any of the symptoms listed above, please explain when symptoms first began; how long symptoms have been present; and if they have been evaluated by a physician?		

EXPOSURE RISK

Questions	YES	NO
Does anyone in your household have any of the symptoms listed above? If yes, please list the symptoms below:		
Has a family member or close contact had TB disease?		
Have you ever had a positive TB screening? If yes, which test was/were positive? ☐ Tuberculin Skin Test (PPD) ☐ QuantiFeron ☐ T-Spot		
Have you ever had a chest x-ray done to rule out tuberculosis? If yes, when was the chest x-ray done? What is the name and address of your physician?		
Have you ever received medication for active tuberculosis disease or preventative treatment for TB infection? If yes, please specify which medication(s). how long they were taken and when treatment was started and completed.		
Were you born in another Country? If yes, where?		
If you were born in another country, did you receive the BCG immunization?		
Have you traveled to a foreign country* for more than 1 month? If yes, indicate where and when **Excludes US, Canada, Australia, New Zealand, or Western and Northern European countries.*		
Do you currently have or have you previously resided or worked in a correctional facility, long-term care facility, hospital, or homeless shelter? If yes, indicate the facility name and dates worked.		

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MEDICAL INFORMATION

List any Medical Conditions you have:
List any Medications you take on a routine basis:

By signing my name, I acknowledge that I have answered the questions above truthfully.

Signature:	
Printed Name:	
SCU ID Number	
Phone:	
Email:	

DO NOT WRITE BELOW THIS LINE

For Office Use Only

RN Reviewing Document

Name:_____

Signature: _____ **Date:** _____

☐ Free to participate in activities

☐ IBRA Blood Test required

☐ Practitioner Appointment required