750

McKINLEY HEALTH CENTER
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

TUBERCULOSIS (TB) SCREENING

(To be completed by student)

Name____ UIN______________________

Country of origin________________________ e-mail address________________________

Local Address___________________________________ Local phone #________________
Street City Zip

How long do you plan to stay in the USA?____

List countries you have been to (besides your home country & USA) in the last 5 years ________________

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<u>Do you have any of the following symptoms?</u>

Cough	☐ No	☐ Yes	Loss of appetite	☐ No	☐ Yes	Weakness	☐ No	☐ Yes
Fever	☐ No	☐ Yes	Night sweats	☐ No	☐ Yes	Weight loss	☐ No	☐ Yes

List any medical problems____

Date of last chest x-ray_____________________ Where was it done?______________________

List medicines you take every day____

List any allergies or adverse reactions to medications_________________________________

Have you ever taken medicine for TB? -- ☐ No ☐ Yes

If yes, when?________________ What kind of medicine?______________________

How long?__________________

Have you ever had the QuantiFERON-TB Gold Test? --- ☐ No ☐ Yes

If yes, when____________________ Results: ☐ Negative OR ☐ Positive

Do you know anyone who has or had tuberculosis (family, friends, school friends, coworkers)? -- ☐ No ☐ Yes

<u>Have you ever had any of the following:</u>

Liver disease (hepatitis)	☐ No	☐ Yes
Steroids or immunosuppressive medications	☐ No	☐ Yes
Chemotherapy or radiation therapy for cancer	☐ No	☐ Yes
Immune deficiency disease	☐ No	☐ Yes
Kidney disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Lung disease (asthma, COPD)	☐ No	☐ Yes
Stomach or intestinal surgery	☐ No	☐ Yes
A blood transfusion	☐ No	☐ Yes
Malnutrition or excessive weight loss	☐ No	☐ Yes
BCG vaccine (Bacillus Calmette–Guérin)	☐ No	☐ Yes

Student Signature_______________________________________ Date____________

---**For Office Use Only**---

☐ Screen Complete ☐ Q-Gold Nurse Signature ____________________________ Date _________