Southwest Virginia Community College Nursing Program

Tuberculosis Symptom Screening Questionnaire

Printed Name: ______________________________Student ID #: _____________ Date: ___________

Symptoms of Active Tuberculosis (TB) Disease (student must check present or not present):	
Coughing that lasts 3 weeks or longer ☐present ☐not present	Pain in the chest ☐present ☐not present
Sweating at night ☐present ☐not present	Weakness & fatigue ☐present ☐not present
Weight loss/no appetite ☐present ☐not present	Coughing up blood or sputum (phlegm from deep inside the lungs) ☐present ☐not present

History (student must check yes or no; comment as needed)			
Question	Yes	No	Comments
Have you ever had an adverse reaction to a TB skin test?			
Were you born outside of the US?			
Have you traveled or lived outside of the US in the past two years?			
Have you ever had a positive reaction to a TB skin test?			
Have you ever had a TB blood test? (test by drawing blood in the lab)			
Have you ever had the BCG vaccine? (not widely used in the US but administered in other countries where TB is common)			
Have you ever been treated for latent TB infection (LTBI)?			
Have you ever been treated for active TB disease?			
Have you had household exposure to TB?			

Student Signature: ____

This Tuberculosis Symptom Screening Questionnaire must be submitted annually while continuously enrolled in the nursing program.

If submitting this questionnaire due to having a previously documented positive TB screening test **or** a documented diagnosis of TB or Latent TB Infection (LTBI), it must be signed below by the healthcare provider (MD, NP or PA) asserting that a symptom review was performed.

Healthcare Provider: Printed Name: ____
Signature: ____ Date: __________________