TB Annual Symptom Review

(for those testing positive on PPD tuberculin [TB] skin test)

SJSU Nursing Student (Print) ____ SJSU#_______________

This assessment has 2 parts and is being done as an annual TB symptom review. If the health care provider completing **PART 2** below deems necessary, further follow-up will be identified below and the SJSU Nursing Student will provide this original form and any other documentation of follow-up. Student should keep a copy for your files at home.

<u>PART 1</u>: (Completed by student prior to seeing Health Care Provider)

<u>TB Symptoms Review</u>

1. Are you currently exhibiting any of the Following symptoms of tuberculosis? / Have you had any of the following within the last 12 months?

Currently		Symptom	Within the last 12 months	
☐ Yes	☐ No	Cough lasting longer than 3 weeks	☐ Yes	☐ No
☐ Yes	☐ No	Coughing up blood	☐ Yes	☐ No
☐ Yes	☐ No	Fever	☐ Yes	☐ No
☐ Yes	☐ No	Weight loss	☐ Yes	☐ No
☐ Yes	☐ No	Night sweats	☐ Yes	☐ No

If the answer is "Yes" to any of the symptoms listed above, please state when symptoms first began; how long symptoms have occurred; and if student has been evaluated by physician for symptoms. ____________________________

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2. ☐ Yes ☐ No Is any person living in your household exhibiting any symptoms of tuberculosis that are listed above? If the client answered "Yes", please list the symptoms. ____________________________________

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3. ☐ Yes ☐ No Have you ever had a chest x-ray done to rule out tuberculosis? If the client answered "Yes", please state when the chest x-ray was done; the name of the physician; and the address and phone number of physicians/agency where it was done.

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4. ☐ Yes ☐ No Have you ever received medication for active tuberculosis disease or preventive treatment for TB infection? If the client answered "Yes", please state name of medications; when the medication was started and completed. ____

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Signature of Student Date

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<u>PART 2</u> (Completed by Physician or Nurse Practitioner):

Printed/Typed name of Health Provider (or legible stamp), indicating name/title:

Health Care Agency affiliation:__________________ (city/state)____

Signature of Health Care Physician/ Nurse Practitioner:______________________________ Date___________

Assessment:____

Any further follow-up, other than annual review questionnaire, in 12 months.

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