

Auraria Tuberculosis (TB) Risk Assessment Questionnaire

Last Name _____ First Name _____ MI _____

Student ID _____

Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth _____ Email _____

Circle School Affiliation: MSCD UCD/HSC CCD AHEC SPRING INTERNATIONAL OTHER _____

1. Are you from or have you lived for two months or more in Asia, Africa, Central or South America or Eastern Europe? No Yes If yes list country(ies) _____

2. Have you been diagnosed with a chronic condition that may impair your immune system?
 No Yes If yes check all that apply

<input type="checkbox"/> Chronic steroid use	<input type="checkbox"/> Gastrectomy/intestinal bypass	<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> HIV infection	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Dialysis/Renal failure
<input type="checkbox"/> Cancer of the head or neck	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Chronic malabsorption syndromes
<input type="checkbox"/> Silicosis	<input type="checkbox"/> Use of TNF- α antagonist	<input type="checkbox"/> low body weight (10% or more below ideal)
<input type="checkbox"/> Leukemia, lymphoma or Hodgkin's disease	<input type="checkbox"/> Other _____	

3. Have you ever resided, worked or volunteered in any of the following facilities?
 No Yes If yes check all that apply

<input type="checkbox"/> Prison	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing home
<input type="checkbox"/> Homeless shelter	<input type="checkbox"/> Other long term treatment center _____	

4. Do you currently have any of the following symptoms?
 No Yes If yes check all that apply

<input type="checkbox"/> Cough \geq 3 weeks	<input type="checkbox"/> Unexplained fever	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Chills
<input type="checkbox"/> Productive cough (coughing up something)	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Respiratory difficulty (shortness of breath)	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weakness

5. Have you ever had contact with a person known to have active tuberculosis?
 Yes No

6. Have you ever used injection drugs?
 Yes No

7. Have you had a positive (reactive) tuberculin skin test before?
 No Yes If yes list where given _____ date ____ / ____ / ____ (Attach results or additional medical documentation.)

The information above is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Signature of Student or Guardian _____ Date _____