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 _____

_____

Do you have any of the following symptoms?

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

Have you ever had any of the following:

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 _____