

University of Miami School of Nursing and Health Studies
ANNUAL TUBERCULOSIS SCREENING & TESTING FORM

Name _____ UM Student # _____
 Last, First M. I.

Do you have a history of prior positive PPD Yes No

If yes –

Chest X-ray Normal Abnormal _____
 month date year

(copy of chest X-ray report must be attached to this form, unless previously submitted)

If PPD was positive and chest X-ray was negative: Was treatment of latent Tb offered? Yes No

Was treatment of latent Tb accepted? Yes No

Details of treatment including drug, dose, frequency and duration:

 Name & title of physician or health care provider Signature Date

If no -

Annual PPD Screening

PPD (Mantoux 5TU only) date placed _____
 month date year

Positive Negative _____ mm induration _____
 month date year

Symptom Review:

Do you have any of the following?

Cough (duration of 3 wks or more)	yes _____ no _____	Night Sweats	yes _____ no _____
Chest Pain	yes _____ no _____	Appetite loss	yes _____ no _____
Hemoptysis (coughing up blood)	yes _____ no _____	Weight loss	yes _____ no _____
Fever	yes _____ no _____	Fatigue	yes _____ no _____
Chills	yes _____ no _____		

 Signature of Student Date

 Name & title of physician or health care provider Signature Date

Address _____

 City State Zip Telephone