Symptom Assessment for Pulmonary Tuberculosis (TB)

Name: ____________________________

Last: ____________________________  First: ____________________________  FDU Student ID#:

Date of Birth: ______/_____/_______  Phone: (                      ) __________________________

Month    Day    Year

Date of Symptom Assessment: ______/_____/_______

(Check all TB-like symptoms that apply):

□ Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)
□ Fever
□ Coughing Up Blood (hemoptysis)
□ Chills
□ Unexplained Weight Loss (10 pounds or greater without dieting)

□ Chest Pain
□ Night Sweats (regardless of room temperature)
□ Very Easily Tired (fatigability)
□ Unexplained Loss of Appetite

□ No TB-Like Symptoms Reported or Observed

If any symptoms are reported, a chest radiograph is required.

Signature of Medical Provider: ____________________________

Date: ____________________________

Print Name: ____________________________

Phone Number: ____________________________

Address: ____________________________

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