TB Exam Clearance Form
Form 4.10

Student/Faculty Name: _____
Student/Faculty ID #: _____ Birth Date: _____
Address: _____City: _____ Zip:_____
Telephone Number _____
Date of last PPD _____ PPD Results _____ MM
Date of IGRA (e.g., Quantiferon/T-Spot) test: _____ Results: _____
Date of Last Chest X-Ray:_____ Results: _____ Positive for TB _____ Negative for TB

1. Have you ever been told you have active TB? ____Yes ____No
2. Have you ever taken INH or any other anti-TB drug? ____Yes ____No
If yes, list names of medications:_____
_____
3. Date and duration of medication regime (months) _____
4. Have you ever had BCG Vaccination? ____Yes ____No If yes, when? _____
5. During the past year have you noticed:

- Unexplained weight loss? ____Yes ____No
- Decrease in your appetite? ____Yes ____No
- Cough not associated with cold or flu? ____Yes ____No
- Increase in AMOUNT of Sputum? ____Yes ____No
- Change in COLOR of Sputum? ____Yes ____No
- Change in CONSISTENCY of Sputum? ____Yes ____No
- Blood Streaked Sputum? ____Yes ____No
- Night sweats? ____Yes ____No
- Unexplained low grade fever? ____Yes ____No
- Unusual tiredness or fatigue? ____Yes ____No
- Swelling of lymph nodes? ____Yes ____No
- Have you had contact with a family member or partner who has been diagnosed with TB? ____Yes ____No
- Have you or a member of your family been exposed to someone who is immune compromised? ____Yes ____ No

Explain any "Yes" answers above:
_____
_____
_____

Evaluation:
_____ I have examined above patient and found them to be free of TB disease. No further action is required

_____ Chest X-ray or TB blood test requested

_____ Further evaluation required

Signature of Health Provider:_____ Date_____
Provider Printed Name: _____