

**University of Illinois at Chicago
College of Nursing
Office of Academic Programs**

ANNUAL TB SCREENING FORM*
(PLEASE COMPLETE THIS FORM ONLY IF YOU HAVE HAD A POSITIVE PPD)

Name: _____ Social Security Number: _____

Have you ever had tuberculosis? Yes ___ No ___

If yes, please explain, including date of positive test, circumstances and treatment involved.

Have you ever had the BCG vaccine? Yes ___ No ___
Year received _____

Have you ever had a positive TB skin test? Yes ___ No ___

Date of the positive test: _____

If you were treated please include the dates treated and type of treatment:

Do you currently have any of the following symptoms?

- Productive or persistent cough (over 2 weeks duration) Yes ___ No ___
- Night sweats Yes ___ No ___
- Fever Yes ___ No ___
- Weight loss Yes ___ No ___
- Loss of Appetite Yes ___ No ___

Unless you provide documentation of positive test, the PPD test must be repeated. This is mandated by the Illinois Department of Public Health.

Signature: _____ Date: _____

* Any Annual TB Screening Form may be submitted.