TB SURVEILLANCE QUESTIONARIE

UNIVERSITY OF ILLINOIS AT CHICAGO
UNIVERSITY HEALTH SERVICES

Name _____ **UIN#** _____

Department _____ **Job title** _____ **Ext** _____

The TB Surveillance Questionnaire reviews the signs and symptoms you could experience if you have active TB. You have received this questionnaire because you either have a positive QuantiFERON TB gold blood test, a positive PPD, or have an allergy to a component of the PPD solution used for skin testing. You will be required to complete this questionnaire periodically in order to maintain TB surveillance compliance. If you experience any of the signs and symptoms at any time please immediately report to UHS and/or your Primary care provider.

Answer the following questions
Explain all yes answers in the comments section:

	YES	NO
1) Are you CURRENTLY experiencing the following symptoms?		
a) Persistent cough for more than two weeks	_____	_____
b) Night sweats	_____	_____
c) Fever	_____	_____
d) Weight loss	_____	_____
e) Bloody sputum	_____	_____
f) Chest pain w/ coughing or breathing.....	_____	_____
2) Do you have diabetes?	_____	_____
3) Do you have an type of lymphatic disease such as lymphoma or Hodgkin's disease?	_____	_____
4) Have you been told you have silicosis or other lung disease?	_____	_____
5) Do you have chronic renal failure?	_____	_____
6) Have you ever had a gastrectomy or gastric bypass?	_____	_____
7) Do you take corticosteroids in amounts > 15mg daily?.....	_____	_____
8) Do you have any other medical condition such as organ transplant 9) that is compromising your immune system?	_____	_____

Comments _____

Employee Signature _____ Date _____

UHS Staff reviewer _____ Date _____

Comments _____