TB SURVEILLANCE QUESTIONNAIRE
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
   that is compromising your immune system? ..............................  ____  ____

Comments _______________________________________________________

Employee Signature_________________________ Date ______

UHS Staff reviewer _____________________________ Date ______

Comments _______________________________________________________

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