Name
Student ID#
Date of Birth
Program/Graduation Year
Phone#
Email
Date _____

## TB Symptom Checklist

**TO BE COMPLETED ANNUALLY IF HISTORY OF POSITIVE PPD**

Make an appointment with your health care provider. Take this form to your appointment.

| **In the past six months have you experienced any of the following for greater than six weeks?** | | |
|---|---|---|
| Excessive sweating at night | yes | no |
| Excessive weight loss | yes | no |
| Persistent coughing | yes | no |
| Excessive fatigue | yes | no |
| Coughing up blood | yes | no |
| Hoarseness | yes | no |
| Persistent Fever | yes | no |

**Circle Result:**