Symptom Assessment for Tuberculosis

To be completed and returned to the Center for Health.

**Traditional Students** complete each Semester. This form is for the _______________ Semester.

**Non-Traditional Students** complete every six months. Date form completed ________________.

(Please Print)

Name: __________________________ Date Of Birth: __________________________

Street_________________________ City________________________ State Zip__________

Primary Telephone __________________________ Alternate Telephone___________________

**Are you experiencing or have you recently experienced any of the following?**

- Unexplained Weight Loss Yes____ No____
- Fever Chills Yes ____ No____
- Night Sweats Yes ____ No____
- Cough for more than 3 weeks Yes____ No____
- Cough up Blood Yes____ No____
- Loss of Appetite Yes____ No____
- Tire easily without reason Yes____ No____
- Chest Pain Yes____ No____

Student Signature: ___________________________________ Date: ________________

For Office Use Only:

Reviewed by Felician College Center for Health ________________________________

Date: ___________________ Last CXR ________________________________

Next form DUE ______________