Initial TB Symptom Review
This form is ONLY for those with previously reactive TB tests.

Today’s Date: ____________________________

1. Have you lost weight in the last 6 months without dieting? Yes ☐ No ☐
   If yes, how much? ____________________________

2. Do you on a regular basis have night sweats or wake up with the sheets wet from sweating? Yes ☐ No ☐
   If yes, how long? ____________________________

3. Do you have a frequent persistent cough? Yes ☐ No ☐

4. Are you bothered by being tired all the time? Yes ☐ No ☐
   If yes, how long? ____________________________

5. Are you bothered by shortness of breath? Yes ☐ No ☐
   If yes, how long? ____________________________

6. Do you cough up blood? Yes ☐ No ☐
   If yes, how long? ____________________________

7. Have you been having increased temperature? Yes ☐ No ☐
   If yes, how long? ____________________________

Approximate Date of reactive PPD: ____________________________

Did you have a chest x-ray done after the reactive PPD? Yes ☐ No ☐
   If yes, what were the results? ____________________________

Were you counseled regarding latent TB? Yes ☐ No ☐
   If yes, where? ____________________________

Did you take medication after the reactive PPD? Yes ☐ No ☐
   If yes, what medicine and for how long? ____________________________

Please return this completed form, along with documentation of your previously positive TB test, chest x-ray report, and proof of counseling to:
MSU Occupational Health
Olin Health Center
463 E. Circle Drive, Room 123
East Lansing, MI 48824-1037
or fax to 517.355.0332

_________________Do NOT write below this line___________________

Review: Negative ☐ Positive ☐ Reviewed by: ____________________________ Date ____________________________