Annual TB Symptom Review

This form is ONLY for those with previously reactive TB tests who have already completed the Initial Symptom Review.

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? ____________________________

Please return this completed form 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 ____________________________

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Updated: 9/29/2010 (Format only – not the questions.)