University Physician's Office

Occupational Health

Name: _____
Date of Birth: _____
If Student: APID: _____
College: _____
If Employee:ZPID _____
Department: _____

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 _____