UNIVERSITY OF HAWAI'I AT MANOA
UNIVERSITY HEALTH SERVICES
Mail to: 1710 East West Road Honolulu, Hawai´i, 96822
Phone (808) 956-8965
Fax to: (808) 956-3583

Tuberculosis Symptom Screening Form

Patient Name _____ ID # _____

This form is to be completed by persons with a previous positive tuberculin skin test and a baseline chest x-ray that was negative for active tuberculosis (TB) disease. Please fax or mail completed form (see above).

This form is to be used for:

- Students with a history of a positive PPD and a normal chest x-ray (results must be on file at the University Health Services) who are transferring from a post-secondary school in Hawai'i to UH-Manoa or re-enrolling into UH-Manoa.
- Employees/Volunteers to comply with the Annual TB Re-evaluation requirement in the State of Hawai'i, such persons must be screened annually for symptoms consistent with TB.

Chest X-ray Date and Result: _____

TB Symptom Screening		**Onset and Duration of Symptoms**
1. Cough for ≥ 3 weeks	❑No ❑Yes	
2. Coughing up blood	❑No ❑Yes	
3. Fever	❑No ❑Yes	
4. Night sweats	❑No ❑Yes	
5. Unexplained weight loss	❑No ❑Yes	Amount:
6. Unusual weakness or fatigue	❑No ❑Yes	

_____ _____
Patient Signature Date

For Office Use Only - TB Symptom Screening Outcome (check one)
NOTE: Refer patient for a chest x-ray to rule out TB if he/she reports having a cough for ≥ 3 weeks duration and at least one of the other symptoms from #2 through #6.
❑ Client does not report TB symptoms at this time. ❑ Client was referred for chest x-ray to rule out TB ❑ Other: Nurses Initial _____

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