VCOM ANESTHESIA BLUEFIELD UNIVERSITY

Master of Health Science in Anesthesia Program
Annual Questionnaire for Individuals w/Positive PPD Skin Test

Name: _____ D.O.B. _____

Date of ***Positive*** PPD exam: _____
*Past BCG? Yes____No____

Past treatment: _____

In order to ensure patient safety, it is required that all students who have positive PPD history complete this questionnaire and have it signed by their physician after an examination annually.

During the past year, did you experience any of the following signs or symptoms? Please circle the appropriate response:

Chronic/persistent cough	Yes	No
Cough or spit up blood	Yes	No
Unexplained significant weight loss/anorexia	Yes	No
Persistent fever > 100 deg. F	Yes	No
Night sweats	Yes	No
Unexplained fatigue	Yes	No
Chest pains	Yes	No
Been advised that you are immunosuppressed for any reason	Yes	No
Loss of appetite	Yes	No
Swollen glands in your neck or elsewhere	Yes	No
Recurrent/persistent kidney/bladder infections	Yes	No
Shortness of breath	Yes	No
Frequent or recurring chills	Yes	No

Persons with a positive PPD who are experiencing symptoms should receive a chest x-ray to assess for pulmonary tuberculosis.

I understand the importance of seeking medical attention if I display any of the above symptoms.
I will also notify my physician of any exposure to Tuberculosis.

Patient Signature:_____Date: _____

Physician Name (print) _____

Physician Signature:_____Date: _____

Return Completed Form to the Student Health Coordinator- Master of Health Science in Anesthesia Program