



Tuberculosis (TB) Screening / Health History Form

This confidential information will only be available to the clinicians in Health Services in accordance with HIPAA regulations. Additionally, students with disabilities and athletes will be asked to complete further information for Student Success and Kinesiology, respectively. HIPAA restricts Health Services from sharing any medical information without written consent by the student.

I understand that this confidential medical information will not be shared outside Calvin Health Services without my consent except in an emergency situation or hospitalization. The Calvin Health Services Privacy Policy is available on our website.

| | |
|----------------|--|
| First Name: | |
| Last Name: | |
| Student ID #: | |
| Date of Birth: | |

Tuberculosis (TB) Screening Questionnaire:

| | |
|---|----------------|
| Have you ever had close contact with persons known or suspected to have active TB disease? | Yes ___ No ___ |
| In what country were you born? | |
| Have you lived in this country in the past 5 years? | Yes ___ No ___ |
| Have you traveled to a country outside of the United States in the past 5 years? | Yes ___ No ___ |
| If yes, complete the following: | |
| • Country 1: | |
| • Dates: | |
| • Purpose: | |
| • Country 2: | |
| • Dates: | |
| • Purpose: | |
| • Country 3: | |
| • Dates: | |
| • Purpose: | |
| • Additional countries/dates/purpose: | |
| Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? | Yes ___ No ___ |
| Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? | Yes ___ No ___ |
| Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? | Yes ___ No ___ |
| Have you ever had a BCG vaccination (A TB vaccine only given in high-risk countries)? | Yes ___ No ___ |
| Have you ever had a positive (abnormal) TB skin or blood test? | Yes ___ No ___ |
| • If yes, what was the date? Date: | |
| • Was it followed up with a chest x-ray? | Yes ___ No ___ |
| (Please send a copy of the x-ray report for TB results 10 mm and greater) | |
| • Did you take medication for treatment? | Yes ___ No ___ |
| Do you currently have any of the following? | |
| • Cough longer than 3 weeks duration | Yes ___ No ___ |
| • Coughing up blood (hemoptysis) | Yes ___ No ___ |
| • Chest pain | Yes ___ No ___ |
| • Loss of appetite | Yes ___ No ___ |
| • Unexplained weight loss | Yes ___ No ___ |
| • Night sweats | Yes ___ No ___ |
| • Fever | Yes ___ No ___ |

| | | |
|-------|---------------|----------------|
| Name: | Student ID #: | Date of Birth: |
|-------|---------------|----------------|

General Medical Information:

Do you carry an EpiPen? Yes ___ No ___ If yes, please explain why: _____

List any Medication Allergies _____

Have you had any of these conditions? (Check all that apply; give dates and relevant information in the space provided)

| | | | |
|-------------------------------------|--|--|--|
| Concussion | | Thyroid | |
| Seizures or epilepsy | | Sickle Cell or Trait | |
| Allergies (receiving allergy shots) | | Bleeding Disorder | |
| History of heart disease | | Depression | |
| Asthma | | Anxiety | |
| Tuberculosis or Positive PPD | | ADD/ADHD | |
| Cohn's/colitis | | Eating disorder | |
| Kidney disease | | Learning Disorder | |
| Cancer | | Other congenital disorder(s) (Please list) | |
| Diabetes | | Other (Please explain) | |
| No Current conditions | | | |

Have you ever had surgery? (Please list and include year)

Have you ever been hospitalized? (Please list and include year)

Have you had any serious illnesses or injuries (excluding hospitalizations)? (Please list and include year)

Are you currently on any medication, including herbals, inhalers, and over-the-counter medications? (Please list medication name(s) and dosage, if known)

Family History:

Has any family member had the following? (Please check all that apply and specify which family member to the right)

| | | | |
|---------------------------------------|--|------------------------|--|
| ADD/ADHD | | Heart Disease | |
| Alcohol or drug abuse | | Hereditary Disease | |
| Allergies/Asthma | | High Blood Pressure | |
| Blood or clotting disorder | | High Cholesterol | |
| Cancer | | Stroke | |
| Depression/other psychiatric disorder | | Tuberculosis | |
| Diabetes | | Other (please explain) | |
| None | | | |

If you do not know your biological family, please check here: _____

If you are still under the care of your home-town family physician / pediatrician, please list provider's contact information:

In the case of an emergency or a hospitalization, I consent to have the medical director of Calvin Health Services advocate as my primary provider to coordinate care while I attend Calvin University if my primary provider is not available. I acknowledge that I have given accurate information above.

Patient Signature

Date