Health History
Tuberculosis Clearance
for individuals with history of previous positive PPD

Name: _____ SID: _____ DOB_____

If you have a history of a positive PPD, please answer the following questions:

1. Date of your last positive PPD skin test: _____

2. Date of your last chest x-ray: _____
   Results: _____

3. Have you received BCG vaccine in the past? : _____
   If yes, Date: _____
   Country: _____

4. Have you taken medication for Tuberculosis treatment? : _____
   If yes, Dates: began_____ ended treatment_____
   Name of Medication(s): _____

Symptoms Review
Review each of the symptoms listed below and indicate if you have experienced any of these symptoms within the last year by checking the appropriate answer.

	Yes	No
1. Productive cough (3 weeks +)	____	____
2. Persistent weight loss without dieting	____	____
3. Persistent low grade fever	____	____
4. Night sweats	____	____
5. Loss of appetite	____	____
6. Swollen glands, usually in the neck	____	____
7. Recurrent kidney or bladder infections	____	____
8. Coughing up blood	____	____
9. Shortness of breath	____	____
10. Chest pain	____	____

Please submit supporting documentation for positive PPD evaluation and treatment including: chest x-ray results, and records indicating treatment with medication.

Signature:_____ Date:_____

Reviewed by: _____, FNP Date: _____

Recommendations for follow-up:
_____
_____
_____