UNIVERSITY OF MIAMI, EMPLOYEE HEALTH
TUBERCULOSIS SCREENING & TESTING FORM

Print last name, first, middle initial	Date of birth	Social Security #
Department Building and Room #	Work phone #	Supervisor

Home Address, Street	City	Zip Code	( ) Telephone #

1. Do you have a history of positive TB skin test? _____ When? _____
2. Have you ever taken medications for TB? _____
3. In what Country were you born? _____
4. BCG is a vaccine for TB. Were you BCG vaccinated? _____ When? _____
5. Do you have direct contact with Patients? _____
6. Do you have a weak immune system? _____
7. Have you had a chest xray in the past 6 months? _____
8. Was it normal? _____
9. Do you have any of the following symptoms?

Persistent cough (greater than two weeks)	Yes _____	No _____
Unexplained weight loss	Yes _____	No _____
Unexplained loss of appetite	Yes _____	No _____
Frequent low-grade fevers	Yes _____	No _____
Night sweats	Yes _____	No _____
Frequent chills	Yes _____	No _____
Frequent fatigue	Yes _____	No _____

10. Allergies: _____
11. _____ I consent to be tested for tuberculosis. I will return at the designated time to have the test read. I understand that failure to return may result in disciplinary action.
12. _____ I decline to be tested secondary to a previous positive skin test. I understand I may be required to obtain a chest xray at no expense to myself.
13. Do you have animal contact at work? Yes _____ No _____
14. If Yes, Name of Species _____

15. Employee signature _____ Date _____

Do not write below this line

Date Placed _____ **Results** _____ **Induration** _____ **Chest Xray Ordered** _____

Angery Testing _____ **XrayResults** _____

Medication prescribed _____

(2- Step testing) ❑ Yes ❑ No PPD - Lot # _____ **Manufacturer name** _____ **Exp. date** _____

Dose (0.1-ml Route - Intradermally ❑ _____

Comments _____

_____

Is this result considered a conversion _____

Health Care Provider signature _____ **Date** _____