UNIVERSITY OF HAWAI'I AT HILO
STUDENT MEDICAL SERVICES
200 West Kawili Street, Hilo, HI 96720
Phone (808) 932-7369
Fax (808) 932-7368

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 who are transferring from a post-secondary school in Hawai'i to UH-Hilo or returning to UH-Hilo after an absence of 1 year or longer
- 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	
NOTE: Refer the 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.			

For HealthCare Provider Use Only - TB Symptom Screening Outcome (check one)

❑ Client does not report TB symptoms at this time.

❑ Client was referred for chest x-ray to rule out TB

❑ Other: _____

_____ _____
Patient Signature Date

_____ _____
Healthcare Provider Signature Date