UNIVERSITY HEALTH CENTER
TB QUANTIFERON SCREENING QUESTIONNAIRE

Name *(Last, First, M.I.):*	
Date of Birth:	NU ID #:
What countries have you lived in or visited in the past 12 months:	

PERSONAL HEALTH HISTORY

Have you had a positive tuberculosis skin test?	☐ Yes	☐ No
If yes, date: Treatment:		
Have you had close contact (family member, friend, other) with anyone who was sick with tuberculosis?	☐ Yes	☐ No
If yes, date: With whom:		
Have you been vaccinated with BCG?	☐ Yes	☐ No
If yes, date:		
Do you feel tired?	☐ Yes	☐ No
Have you lost weight recently?	☐ Yes	☐ No
Is your appetite normal?	☐ Yes	☐ No
Do you sweat heavily at night?	☐ Yes	☐ No
Do you have a cough?	☐ Yes	☐ No
Do you have a fever?	☐ Yes	☐ No
Do you have diabetes?	☐ Yes	☐ No
Are you taking anti-inflammatory steroids?	☐ Yes	☐ No
Do you have a history of cancer?	☐ Yes	☐ No
Do you have lung disease?	☐ Yes	☐ No
Do you have a blood disorder?	☐ Yes	☐ No
Are you receiving immunosuppressive treatment?	☐ Yes	☐ No
Are you receiving cancer treatment?	☐ Yes	☐ No