TOURO UNIVERSITY
CALIFORNIA

# Form C: TB Symptom Survey

***Student completes the questionnaire. Must be reviewed and signed by the provider***

Name _____ DOB:_____ Program/ Graduation Yr. _____
**Please Print**

**Phone:** _____

## Annual Symptom Survey

**The Symptom Survey is required annually for anyone with a current or past positive PPD.**

During the past year have you had any of the following symptoms?

| | |
|---|---|
| Unexplained weight loss? | Yes ☐ No ☐ |
| Decrease in appetite? | Yes ☐ No ☐ |
| Persistent cough? | Yes ☐ No ☐ |
| Blood streaked sputum? | Yes ☐ No ☐ |
| Night Sweats? | Yes ☐ No ☐ |
| Unexplained low grade fever? | Yes ☐ No ☐ |
| Swelling of the lymph nodes? | Yes ☐ No ☐ |
| Unusual tiredness or fatigue? | Yes ☐ No ☐ |

Date of last CXR: _____ pos ☐ neg ☐

Date of last QFT: _____ pos ☐ neg ☐

Student's Signature: _____Date:_____

Provider's Signature: _____ Date: _____

Provider's Printed Name: _____

**Providers address or stamp:**