Nebraska Medicine Employee Health Annual TB Screening

Phone: 402-552-3563 Fax: 402-552-2025 Campus Zip: 8444

Name:	**Date of Birth:**	**Date:**
Last 4 of SSN:	**Dept/Manager/Campus Zip:** Volunteer Services / Patty Ostronic / 7509	

1. Have you ever had a reaction to a TB test?

☐ **Yes** ☐ **No**

a. If yes, please indicate which specific test was positive

☐ **TB skin test only**

☐ **TB interferon blood test only**

☐ **Both TB skin test and TB interferon blood test**

☐ **Unsure**

b. If yes, was medication prescribed for you?

☐ **Yes** ☐ **No**

c. If yes, did you complete the medication?

☐ **Yes** ☐ **No**

1. Were you a temporary or permanent residence of one month or more in a country with a high TB rate <u>since your last TB screen</u>? (Any country other than the United States, Canada, Australia, New Zealand, and those in the Northern Europe or Western Europe)

☐ **Yes** ☐ **No**

2. Have you had unprotected (no PPE or use of a surgical mask rather than an N95 respirator) contact with someone who has had infectious TB <u>since your last TB screen</u>?

☐ **Yes** ☐ **No**

3. Are you currently or plan to be immunosuppressed, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g. infliximab, etanercept, or other), chronic steroids (equivalent of prednisone 15 mg/day or more for 1 month or longer) or other immunosuppressive medication?

☐ **Yes** ☐ **No**

PULMONARY SYMPTOMS REVIEW (in the past 6 months, have you had any <u>UNEXPLAINED PERSISTENT</u> symptoms of):

1. Persistent cough lasting more than 3 weeks?

☐ **Yes** ☐ **No**

2. Coughing up blood?

☐ **Yes** ☐ **No**

3. Fever?

☐ **Yes** ☐ **No**

4. Weight Loss?

☐ **Yes** ☐ **No**

5. Night Sweats?

☐ **Yes** ☐ **No**

6. Weakness or Fatigue?

☐ **Yes** ☐ **No**

Signature:____