

MOREHOUSE SCHOOL OF MEDICINE
Student and Employee Wellness Center
1513 E. Cleveland Ave, Bldg. 500-B
East Point, Ga. 30344
404-756-1241

PREVIOUS POSITIVE TB SKIN TEST ANNUAL EVALUATION

Date:

Student/Resident Name:

TERM:

DOB

DEPT:

Have you ever had a positive reaction to a TB Skin Test? _____Yes _____ No

Date of last CXR:

(

(If yes: answer the following questions)

Persistent cough longer than 2 weeks	____Yes	____No
Hemoptysis	____Yes	____No
Chest Pain	____Yes	____No
Fever, Chills	____Yes	____No
Night Sweats	____Yes	____No
Unexplained weight loss	____Yes	____No
Poor Appetite	____Yes	____No
Fatigue	____Yes	____No

Signature of Student/Resident: _____

Signature of Health Care Provider: _____