West Valley-Mission Community College District
Student Health Services

Are you:
❑ Student
❑ Employee

TUBERCULOSIS SURVEILLANCE FORM

NAME: _____ DATE: _____

DATATEL ID #: _____ SOC. SEC. #: _____

BIRTH DATE: _____ BIRTHPLACE: _____

❑ WEST VALLEY ❑ MISSION

When did you have your last skin test for TUBERCULOSIS? Date: _____

What was the result? _____ mm Positive

Where was the skin test performed? _____

When did you have your last chest x-ray for TUBERCULOSIS? Date: _____

What was the result? ❑ Negative ❑ Positive

Where was the chest x-ray performed? _____

Have you ever taken, or are you now taking, medication because your TUBERCULOSIS skin test was positive? ❑ Yes ❑ No

Have you received a BCG vaccination in the **past year**? ❑ Yes ❑ No

Please indicate "yes" or "no" to the following questions with regard to your experience during the past year:

	YES	NO
1. Have you or do you have any lung problems such as bronchitis, emphysema, asthma, or chronic cough?		
2. Has anyone in your family, close friends, or co-workers developed TUBERCULOSIS, or had their TUBERCULOSIS skin test change from a negative to positive reading? If yes, please describe:		
3. Have you ever coughed up blood? If yes, please describe:		
4. Have you had any unexplained cough for over 2 to 3 weeks? If yes, please describe:		
5. Have you had any unexplained appetite loss or weight loss of more than ten (10) pounds within six (6) months? If yes, please describe:		
6. Have you had any unexplained sweating, especially at night? If yes, please describe:		
7. Have you had any unexplained fevers? If yes, please describe:		
8. Have you had any unexplained chest pain? If yes, please describe:		
9. Has anyone in your family, close friends or co-workers developed any of the above-mentioned symptoms? If yes, please describe:		

Patient's Signature _____ Date: _____

Referral for follow-up: ☐ Yes ☐ No Date: _____

Referred to: _____

Health Care Provider's Name (Please Print) _____

Health Care Provider's Signature _____

Date: _____ Phone: _____