UNIVERSITY OF NEW ENGLAND

Student Health Services

Annual Tuberculosis Symptom Assessment

Name: _____ DOB: _____

Date of Examination: _____ (within one year of matriculation)

B/P_____ Temp _____ Pulse _____ WGT _____ HGT_____

Allergies: _____ Medication: _____

Reason for symptom Assessment: _____

To Be Completed by a Health Care Provider

	YES	NO	COMMENT
Has the student/patient experienced any problems with a persistent cough?			
Has the student/patient noticed any blood in their sputum?			
Has the student /patient experience any night sweats?			
Has the student/ patient had a fever recently?			
Has the student/ patient experienced loss of appetite and/or weight loss lately?			
Does anyone the student/ patient associates with have tuberculosis?			
Has the student/patient seen a healthcare professional in the past year for any physical ailments?			

The student/ patient has been determined to be_____ asymptomatic_____ symptomatic for tuberculin infection.

If symptomatic, please describe your recommendation to student/patient for follow-up care: _____

_____

_____

Print Health Care Provider's Name: _____

Health Care Provider Signature: _____Date:_____

Address: _____

Phone: _____

Please mail or fax forms to Student Health Services at the appropriate campus

11 Hills Beach Rd

Biddeford, ME 04005

Tel: (207) 602-2358

Fax: (207) 602-5904

716 Stevens Ave.

Portland, ME 04103

Tel: (207) 221-4242

Fax: (207) 523-1913

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