



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

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|----------------------------|----------------------------|
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| Biddeford, ME 04005 | Portland, ME 04103 |
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