University of Miami Nursing/Medical/Physical Therapy
Annual Tuberculosis Screening Form

Name _____ Date of Birth: _____
Last, First M. I.

Student ID: _____

Symptom Review: Must be completed by all students upon enrollment and then annually.

Do you have any of the following?

Cough (duration of 3 wks or more)	yes _____ no _____	Night Sweats	yes _____ no _____
Chest Pain	yes _____ no _____	Appetite loss	yes _____ no _____
Hemoptysis (coughing up blood)	yes _____ no _____	Weight loss	yes _____ no _____
Fever	yes _____ no _____	Fatigue	yes _____ no _____
Chills	yes _____ no _____		

_____ _____
Signature of Student Date

*If you answer 'yes' to any of the above questions, please schedule an appointment with a Student Health provider.