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: __________________
(*CXR Documentation MUST be within 12 months of date of entry to MSM.)*

(If yes: answer the following questions)

Do you have or had in the past year any of the following symptoms that cannot be explained?

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**

If one or more symptoms present, obtain 2 view CXR and attach results.

Signature of Student/Resident: ____

Signature of Health Care Provider: _______________________________________

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