STUDENT HEALTH CENTER
4505 Maryland Parkway, Box 453020
Las Vegas, NV 89154-3020
(702) 895-3370

Tuberculosis Questionnaire and Skin Test

Last Name **First Name** **MI** **Date of Birth** **SSN/ Student ID No.**

Answer YES or NO to the following questions. If the answer to any of the questions is "Yes" the SHC nurse will evaluate you for more detailed assessment.

	Yes	No
1. Have you had a Measles injection in the last 30 days?	❒	❒
2. Have you ever had a **TB SKIN TEST**?	❒	❒
3. Have you ever had a positive reaction?	❒	❒
4. Have you ever had a **BCG** injection?	❒	❒
5. Have you ever had a **TB SKIN TEST** in the last **six weeks**?	❒	❒
6. Have you ever had Tuberculosis?	❒	❒
7. Have you ever had contact with and/or been exposed to anyone with tuberculosis?	❒	❒
8. Have you had a Chest X-ray in the last 6 months?	❒	❒
9. **Females**: Are you pregnant?	❒	❒
10. Has a doctor advised you or is there any reason that you should not have a TB test?	❒	❒

If yes, why_____

I hereby certify that the above answers are true to the best of my knowledge, and I request a TB Skin Test to be completed at the Student Health Center. I understand I must return 48 to 72 hours for a **TB reading** for this test to be considered valid.

_____ _____
Patient Signature Date

ONE STEP

PPD test Lot #:_____Exp. Dt:_____
Date Given:_____
Given By:_____
Injection Site: ❒ Rt. ❒ Lt. Forearm
MM INDUR:_____
Read By:_____ Date Read_____

TWO STEP

PPD test Lot #:_____Exp. Dt:_____
Date Given:_____
Given By:_____
Injection Site: ❒ Rt. ❒ Lt. Forearm
MM INDUR:_____
Read By:_____Date Read_____

----------CUT ALONG THIS LINE----------

UNLV Student Center Health
4505 Maryland Pkwy
Box 453020
Las Vegas, Nevada 89154
(702) 895-3370

On _____ a PPD/TB Skin Test was given to _____
Date Patient Name

and was read on_____ with an induration of _____MM.

_____
R.N. Signature

----------CUT ALONG THIS LINE----------

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On _____a PPD/TB Skin Test was given to _____
Date Patient Name

and was read on_____with an induration of_____MM.

_____

Original- Patient file Copy- Patient

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R.N. Signature