TB SCREENING FORM

Name: _____ Student ID#:_____ Date: _____

School: _____ Birth date: _____/_____/_____ Phone: _____
MM DD YYYY

Please indicate if you have any of the following symptoms:

Yes	No	
☐	☐	Chronic cough
☐	☐	Production of sputum – if yes, what color sputum: _____
☐	☐	Blood-streaked sputum
☐	☐	Unexplained weight loss
☐	☐	Unexplained fatigue/tiredness
☐	☐	Night sweats
☐	☐	Fever

4/19/16

LOMA LINDA UNIVERSITY HEALTH
Center for Health Promotion

Student Health Service
24785 Stewart St. Evans Hall, Ste. 111
Loma Linda, CA 92354
Phone: (909) 558-8770
Fax: (909-558-0433

TB Screening Form

PATIENT IDENTIFICATION

Name:

Birth Date:

Medical Record #: