

**HOWARD UNIVERSITY STUDENT HEALTH CENTER**  
**Risk Assessment for Tuberculosis Exposure or Infection**

1. Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_  
Last First MI

2. DOB: \_\_\_/\_\_\_/\_\_\_ Gender: M F Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

3. Ethnicity: (Please check)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Cuban American    | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian American                    | <input type="checkbox"/> Hispanic or Latin | <input type="checkbox"/> Puerto Rican American                     |
| <input type="checkbox"/> Black or African American         | <input type="checkbox"/> Mexican American  | <input type="checkbox"/> White or Caucasian                        |
| <input type="checkbox"/> Other: List: _____                |  |  |

4. Were you born in the USA? Y N Place of Birth \_\_\_\_\_  
City/State

5. Country of Birth: \_\_\_\_\_

6. Year arrived in the U.S: \_\_\_\_\_

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7. Have you had any of the following symptoms for at least 2 weeks? (These symptoms should represent a change from normal ).  
 Please complete **both** sides. Circle Y for Yes, N for No.

- |  |     |
|--|-----|
| *A. Cough and/or Blood in the sputum? (for example coughing up blood)                          | Y N |
| *B. Fever and/or Night Sweats? (soaking, drenching night sweats requiring change of linen)     | Y N |
| *C. Unintentional significant weight loss (at least 10% body weight) over the past 3-6 months? | Y N |

8. Have you ever been tested for HIV?  Negative \_\_\_\_\_  Positive \_\_\_\_\_ Y N  
Date \*Date

9. Do you have any sexual risk factors for HIV? (Unprotected sex, sex with an intravenous/IV drug user, MSM) Y N

10. \*Have you ever lived with or been in close contact with someone with active tuberculosis? Y N

- |   |      |
|---|------|
| A. Have you ever had a tuberculin skin test (PPD) ? _____                             | Y N* |
| <small>Date</small>   |      |
| *B. Were you told that the skin test was positive/reactive?                           | Y N  |
| C. Did you have a chest x-ray? If yes, when? _____                                    | Y N  |
| <small>Date</small>   |      |
| *D. Were you given medicine for a positive PPD/Chest x-ray and/or tuberculosis? _____ | Y N  |
| <small>Date/medicine</small>  |      |

11. Have you ever:

- |   |     |
|---|-----|
| *A. Injected illegal drugs?   | Y N |
| *B. Been homeless or worked /volunteered with the homeless?   | Y N |
| *C. Lived in a refugee camp or worked/ volunteered in a refugee camp?   | Y N |
| *D. Been incarcerated or worked /volunteered in a jail or prison?   | Y N |
| *E. Lived or worked /volunteered in a group home, e.g., half-way house, drug treatment center, mental health center or a juvenile detention center? | Y N |
| *F. Been part of medically underserved population or worked/volunteered with migrant farm workers or other impoverished populations?                | Y N |
| *G. Worked as a health care provider or volunteered in a health care facility?  | Y N |

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**12. Have you ever:**

- \*A. Been on prolonged immunosuppressive therapy, prednisone or chemotherapy? Y N
- \*B. Been diagnosed with head/ neck cancer, lymphoma or leukemia? Y N
- \*C. Had surgery to have all or part of your stomach removed? Y N
- \*D. Been diagnosed with Diabetes? Y N
- \*E. Been diagnosed with serious kidney problems requiring dialysis? Y N
- F. Vaccinated with BCG? Date: \_\_\_\_\_ Y N

**13. \*Were you born in (B), lived in (L) or traveled to (T) within the last 5 years to any of the following countries?  
(Circle all that apply; Specify country under "Other Region" if not listed)**

- |  |                           |
|--|---------------------------|
| <b>B L T</b> Afghanistan                               | <b>B L T</b> Mexico       |
| <b>B L T</b> Bangladesh                                | <b>B L T</b> Nigeria      |
| <b>B L T</b> Brazil                                    | <b>B L T</b> Pakistan     |
| <b>B L T</b> Burma                                     | <b>B L T</b> Peru         |
| <b>B L T</b> Cambodia                                  | <b>B L T</b> Philippines  |
| <b>B L T</b> China                                     | <b>B L T</b> South Africa |
| <b>B L T</b> Former USSR/Russian Federation            | <b>B L T</b> Sudan        |
| <b>B L T</b> Congo                                     | <b>B L T</b> Tanzania     |
| <b>B L T</b> Ethiopia                                  | <b>B L T</b> Thailand     |
| <b>B L T</b> India                                     | <b>B L T</b> Uganda       |
| <b>B L T</b> Indonesia                                 | <b>B L T</b> Viet Nam     |
| <b>B L T</b> Iraq                                      | <b>B L T</b> Zimbabwe     |
| <b>B L T</b> Kenya                                     |                           |
| <b>B L T</b> Other African Region: _____               |                           |
| <b>B L T</b> Other American Region: _____              |                           |
| <b>B L T</b> Other Eastern Mediterranean Region: _____ |                           |
| <b>B L T</b> Other European Region: _____              |                           |
| <b>B L T</b> Other South East Asian Region: _____      |                           |
| <b>B L T</b> Other Western Pacific Region: _____       |                           |

I certify that these answers are true to the best of my knowledge: \_\_\_\_\_ Date: \_\_\_\_\_  
 Student Signature

**NOTE: THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER or CLINICIAN AS INDICATED BELOW.**  
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**Provider/Clinician Review:** \* PPD is indicated if the student has never had a previous PPD and/or if any of the questions with an asterisk have a **Yes** answer or a positive response. **Please check the appropriate statement below:**

\_\_\_\_\_ **The student is not to receive a PPD today.** I have reviewed this questionnaire with the student and have determined by protocol that he/she has not met the criteria for tuberculosis exposure/infection and requires no further evaluation at this time.

\_\_\_\_\_ I have reviewed this questionnaire with the student and have determined by protocols that he/she has met the criteria for tuberculosis exposure testing.

**Today he/she may receive (Check one)  PPD  Chest x-ray**

Comments: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_  
 Health Care Provider or Clinician Signature and Title