UNIVERSITY OF FLORIDA
STUDENT HEALTH CARE CENTER
Tuberculosis (TB) Surveillance Form

Name: _______________________________ Phone: __________________________

UFID#: ______________________________ Date of Birth: ______________________

**NOTE:** This form is for those with a history of positive TB skin test only!

Please answer all of the following questions and sign below at the “**”.

1. Have you had a chronic (more than four weeks):

<table>
<thead>
<tr>
<th>Chest Congestion</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

   | Hoarseness       | Y | N |
   | Night Sweats     | Y | N |

   | Fevers           | Y | N |
   | Weight Loss      | Y | N |

2. Have you been exposed to TB? (for example: Direct contact with a person with TB in the past six months?)

   NO   YES  If yes, name of person (if known): ____________________________

* _______________________________ _______________________________
Signature Date

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**DO NOT WRITE BELOW THIS LINE**

Comments: ____________________________________________________________

___________________________________________
Authorized Signature Date