Department of Nursing
Tuberculosis Risk Assessment
For individuals with a history of a positive TB test. This form should be completed and submitted to the compliance system as directed.

NAME (printed): ____________________________ DATE: __________

Please answer the following questions and provide additional information for any YES answers.

1. Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?  
   YES  NO

2. Have you traveled outside of the USA and lived for more than one month in Africa, Asia, Central America, South America, or Eastern Europe?  
   Date and duration of last travel to these countries: __________________________
   YES  NO

3. Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medications (e.g. Prednisone, Remicade), leukemia, lymphoma cancer or the head or neck, gastrectomy or jejunal bypass, end stage renal disease (on dialysis), or silicosis?  
   Date of onset of any of the above conditions: __________________________
   YES  NO

4. Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in a jail or prison, worked or resided in a homeless shelter, or worked as a healthcare worker in direct contact with patients?  
   Date of use of any of the above conditions: __________________________
   YES  NO

5. Have you experienced any of the following symptoms in the past year?  

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>YES</th>
<th>NO</th>
<th>Symptoms</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td>Night sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td></td>
<td></td>
<td>Low grade fever</td>
<td></td>
<td></td>
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<tr>
<td>Loss of appetite</td>
<td></td>
<td></td>
<td>Chest pain</td>
<td></td>
<td></td>
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<tr>
<td>Weakness</td>
<td></td>
<td></td>
<td>Bloody sputum</td>
<td></td>
<td></td>
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<tr>
<td>Persistent cough**</td>
<td></td>
<td></td>
<td>Prolonged period of “just not feeling well”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you followed up with your health care provider regarding any categories with “yes” answers?  
   YES  NO

Answers of “Yes” should be discussed with the ASU Nursing Director of Compliance and Student Support

Date of last CXR (or not applicable (n/a)): __________________________

Radiologist Report submitted to ASU Nursing Program:  
   YES  NO

Date completed medication for active or latent tuberculosis (or not applicable (n/a)): __________________________

This information will be evaluated and you may be required to have a statement of clearance to participate in clinical from a healthcare provider of your choice.

The above information is accurate to the best of my knowledge.

Student signature: ____________________________ Date: __________

Reviewed by: ____________________________ Date: __________

Reviewer Comments: ____________________________

Reviewer Signature: ____________________________