TUBERCULIN SKIN TESTING QUESTIONNAIRE FOR COLLEGE STUDENTS

**Arkansas Department of Health - Tuberculosis Program**

Box 1:

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_

Student ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_Age: \_\_\_\_\_\_

Social Security #:\_\_\_\_ -\_\_\_-\_\_\_\_\_ Enrollment Date: \_\_\_\_\_\_\_\_\_\_ Gender: M F

Phone Number (cell phone preferred): (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Box 2:

Race: Hispanic: Y N

Circle one: White Black Asian Pacific Islander American Indian Other: \_\_\_\_\_\_\_\_\_\_\_   
  
Box 3:

On what date did you enter the US? (mm/dd/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In what Country were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a permanent resident of the United States? Y N If yes, stop here. Submit form to UAM Student Health Services via email [Richardson@uamont.edu](mailto:Richardson@uamont.edu) or fax 870-460-1653, attention Terri.

Are you a US Citizen? Y N If yes, stop here. Submit form to UAM Student Health Services via email [Richardson@uamont.edu](mailto:Richardson@uamont.edu) or fax 870-460-1653, attention Terri.

Box 4:

Have you been out of the United States in the last 5 years? Y N  
If yes, Most recent year of travel (yyyy): \_\_\_\_\_\_\_\_  
Have you ever been to: (circle, if yes)  
Africa Asia South America Eastern Europe Middle East Other:\_\_\_\_\_\_\_\_  
Box 5:

Did you receive a BCG vaccine as a child? Y N Unk

Have you had an HIV test? Y N If yes, Date (yyyy): \_\_\_\_\_\_\_ If yes, Result? + -

Box 6:

**Have you had a recent (within the past 3 months) TB Skin Test performed in the US?** **Y N**

If yes, Date applied: \_\_\_\_\_ Reading:\_\_ mm Date Read: \_\_\_\_\_ Provider:\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_ State\_\_\_

**Have you had a TB Blood Test (IGRA or T-Spot) performed in the US within the past 3 months? Y N**

If yes: Reading (mm): \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_\_\_\_\_ Positive/Negative (circle)

Where did you receive the blood test? Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_ State:\_\_

Box 7:

**Most recent chest radiograph (x-ray), if applicable:**

Date (mm/dd/yy): \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Box 8:

Have you been recommended for and received treatment for latent (inactive) TB? Y N

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date treatment started: \_\_\_\_\_\_ Date treatment completed:\_\_\_\_\_\_