Wichita State University Student Health Services Tuberculosis Evaluation

Family Name/Last Name/Surname _____ First Name(s)/Given Name(s) _____ Middle Name(s) _____ myWSU ID# _____

Birth Date (MM/DD/YY) _____ Local Street address (ex: 4000 E. 17th St., #9 Wichita, KS 67208) _____ Phone Number ( ) _____

Field of Study (i.e. nursing, education, PT etc.)_____

Every section must be completed. Please mark all that apply. If nothing applies, mark "None."

Section A (Personal History)	
Country of Birth and Travel History	☐ Born in USA ☐ If not born in the USA, Country of Birth (specify)_____Arrival Date in USA: _____
	Since your last TB test: Have you ever traveled outside the USA? ☐ No ☐ Yes If yes, where?_____For how long? _____ Have you resided in another country for more than three months? ☐ No ☐ Yes If yes, where?_____When? _____

Section B (Medical History and TB Risk Factors)

In the past year have you lived, worked, or volunteered in a:

☐ health care facility ☐ long term care facility ☐ homeless shelter
☐ mycobacteriology lab ☐ rehabilitation center ☐ correctional facility ☐ **None**

Section C (Review of Symptoms) Are you having any of these symptoms right now:

☐ Productive cough (lasting longer than 3 weeks); Date of onset____/____/____
☐ Weight loss
☐ Coughing up blood or sputum
☐ Swollen lymph glands of the neck, axilla, groin, etc.
☐ Fever (recurrent)
☐ Fatigue (severe)
☐ Blood in urine
☐ Pain in the chest
☐ Shortness of breath
☐ Night sweats
☐ **None**

I consent to this paper/electronic screening for TB. If Student Health Services determines that I need further testing, I also consent to receiving TB testing and chest x-rays as needed to screen for TB. I understand that if I am considered by Student Health Services to be a high-risk student, I am not to attend any classes until my TB evaluation is complete.

If additional information is needed or parts of this form are not complete, you will be contacted by Student Health Services staff at the email address used to submit this form.

Students will need to complete this form and upload it through the myShockerHealth portal. Link to the portal and instructions on how to upload documents can be found at www.wichita.edu/shs

Patient's Signature _____ Today's Date _____