Bergen Community College
Health Services Room HS100
Annual Tuberculosis Screening Questionnaire
Submit forms to https://lf.bergen.edu/forms/hs0001
Email healthservices@bergen.edu

Name: _____ **Program:** _____
(Please Print Clearly)

Student ID: _____ **DOB:** _____

Email: _____ **Cell No:** _____

Please complete the following questions:
Are you experiencing any of the following?

1.	Fatigue, Malaise	YES	NO
2.	Unexplained Weight Loss	YES	NO
3.	Anorexia (loss of appetite)	YES	NO
4.	Fever (usually at night)	YES	NO
5.	Night Sweats (drenching proportions)	YES	NO
6.	Cough	YES	NO
7.	Hemoptysis (spitting up blood)	YES	NO
8.	Pain in Chest	YES	NO

If you answered yes to any of the above, please explain.

_____

_____

_____

Student Signature: _____ **Date:** _____

Health Services Medical Staff will review the answers you have provided, if any of the questions were answered **"YES"** a TB test will be required.

Rev 02/2002