Bergen Community College
Annual Tuberculosis Screening Questionnaire

Name: _____ **Dept:** _____
(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 and if any of the questions were answered “YES” a TB test will be required.