

**UNIVERSITY OF FLORIDA  
STUDENT HEALTH CARE CENTER  
Tuberculosis (TB) Surveillance Form**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

UFID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**NOTE: This form is for those with a history of positive TB skin test only!**

**Please answer all of the following questions and sign below at the "\*".**

1. Have you had a chronic (more than four weeks):

Chest Congestion	<b>Y</b>	<b>N</b>	Hoarseness	<b>Y</b>	<b>N</b>	Fevers	<b>Y</b>	<b>N</b>
Cough	<b>Y</b>	<b>N</b>	Night Sweats	<b>Y</b>	<b>N</b>	Weight Loss	<b>Y</b>	<b>N</b>

2. Have you been exposed to TB? (for example: Direct contact with a person with TB in the past six months?)

NO    YES    If yes, name of person (if known): \_\_\_\_\_

\* \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**DO NOT WRITE BELOW THIS LINE**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date