FELICIAN UNIVERSITY

Center for Health, One Felician Way, Rutherford, NJ 07070
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Symptom Assessment for Tuberculosis

To be completed and returned to the Center for Health.

Traditional Students complete each Semester. This form is for the _____ Semester.

Non-Traditional Students complete every six months. Date form completed _____.

(Please Print)

Name: _____ Date Of Birth: _____

Street_____City_____State_____Zip_____

Primary Telephone _____Alternate Telephone_____

Are you experiencing or have you recently experienced any of the following?

Unexplained Weight Loss	Yes_____No_____
Fever Chills	Yes _____No_____
Night Sweats	Yes_____No_____
Cough for more than 3 weeks	Yes_____No_____
Cough up Blood	Yes_____No_____
Loss of Appetite	Yes_____No_____
Tire easily without reason	Yes_____No_____
Chest Pain	Yes_____No_____

Student Signature: _____Date: _____

For Office Use Only:

Reviewed by Felician University Center for Health
_____

Date: _____ Last CXR_____

Next form DUE _____