THE LEADER IN GLOBAL EDUCATION

FAIRLEIGH DICKINSON UNIVERSITY

STUDENT HEALTH SERVICES
Metropolitan Campus
1000 River Road, T-SU2-03
Teaneck, New Jersey 07666
Phone: (201) 692-2437
Fax: (201) 692-2642

Symptom Assessment for Pulmonary Tuberculosis (TB)

Name: ____
Last First FDU Student ID#

Date of Birth: _______/_______/_______ **Phone:** (   ) ________________________
Month Day Year

Date of Symptom Assessment: _______/_______/_______
Month Day Year

(*Check all TB- like symptoms that apply):*

☐Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)
☐Fever
☐Coughing Up Blood (hemoptysis)
☐Chills
☐Unexplained Weight Loss (10 pounds or greater without dieting)
☐Chest Pain
☐Night Sweats (regardless of room temperature)
☐Very Easily Tired (fatigability)
☐Unexplained Loss of Appetite

☐*No TB-Like Symptoms Reported or Observed*

If any symptoms are reported, a chest radiograph is required.

Signature of Medical Provider: ______________________________ **Date:** ________________

Print Name: ____

Phone Number: ____

Address: ____

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OFFICE STAMP OR PROVIDER LICENSE NUMBER