UNIVERSITY OF CAMBRIDGE

OHF40 CONFIDENTIAL

Occupational Health

Tuberculosis Screening Questionnaire

Surname ..... First name .....

College/department ..... Date of Birth .....

Email ..... Date .....

Data Protection Information

The information that you supply on this questionnaire will be held in confidence by the University Occupational Health Service as part of your occupational health record. For full details of how your personal information is used by the University Occupational Health Service, please see http://www.oh.admin.cam.ac.uk/general-information/confidentiality-statement

Please answer Yes (Y) or No (N) to the following questions.

	Y	N	Comments
1. Immunisation and investigation history			
Have you:			
(a) Had a BCG vaccination?	☐	☐	*If yes please give date of vaccination:*
If 'yes' do you have: a visible BCG scar?	☐	☐	*If yes please give site on body:*
documented evidence of BCG vaccine?	☐	☐	
(b) Had a PPD screening test, i.e. Heaf or Mantoux test?	☐	☐	*If yes please give dates and results:*
(c) Had an Interferon Gamma Release Assay (IGRA)/ QuantiFERON – TB Gold or T-Spot blood test?	☐	☐	*If yes please give date and result:*
(d) Had a chest x-ray?	☐	☐	*If yes please give date and result:*
If 'yes' do you have a copy of the report?	☐	☐	
2. Symptom history			*If yes to any of the questions below please give dates and details:*
Have you:			
(a) any history of tuberculosis (TB) infection?	☐	☐	
(b) in the past year had:			
• a cough lasting for more than 3 weeks?	☐	☐	
• weight loss for no obvious reason?	☐	☐	
• a persistent fever?	☐	☐	
• heavy night sweats?	☐	☐	
• fatigue or a general or unusual sense of tiredness?	☐	☐	
• loss of appetite?	☐	☐	
• coughing up blood (haemoptysis)?	☐	☐	
• swollen glands or joints?	☐	☐	
• recurrent/persistent kidney/bladder infections?	☐	☐	
3. Risk factors			
(a) In which country were you born?			*Country……*
Have you:			
(b) had any family history of TB?	☐	☐	*If yes please give dates and details:*
(c) had household or close lengthy contact with somebody with infectious TB?	☐	☐	
(d) participated in high risk work over the last year?	☐	☐	
4. High prevalence areas			*If yes please give **dates and duration** for each country:*
Have you lived or worked in a country with a high rate of TB i.e., >40/100,000 per population for more than 3 months continuously or cumulatively? See link below for details: https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22charts%22&lan=%22EN%22&iso2=%22AF%22&entity_type=%22country%22 (view data table tab)	☐	☐	
5. Current / recent illness			*If yes please give dates and details:*
Have you any history of the following:			
(a) immunosuppressive or corticosteroid therapy?	☐	☐	
(b) a malignant condition?	☐	☐	
(c) HIV?	☐	☐	
6. Recent vaccinations			*If yes please give dates and names of vaccines:*
Have you received any vaccinations within the last 4 weeks?	☐	☐	

Student/employee signature: ..... Date: .....

For Occupational Health use only

Surname: ..... First name: .....

Initial assessment

	Yes	No		Yes	No
Mantoux test required	☐	☐	To discuss with OHP	☐	☐
Quantiferon TB test (IGRA) required	☐	☐	OHP appt required	☐	☐
Chest X-ray required	☐	☐	Screening complete	☐	☐

OHA/OHCN/OHT signature: ..... Name stamp: .....

Date:

Before repeat IGRA test

Since your last IGRA test have you had:	**Y**	**N**	*If yes to any of the questions please give dates and details:*
• a cough lasting for more than 3 weeks?	☐	☐	
• weight loss for no obvious reason?	☐	☐	
• a persistent fever?	☐	☐	
• heavy night sweats?	☐	☐	
• fatigue or a general or unusual sense of tiredness?	☐	☐	
• loss of appetite?	☐	☐	
• coughing up blood (haemoptysis)?	☐	☐	
• swollen glands or joints?	☐	☐	
• recurrent/persistent kidney/bladder infections?	☐	☐	
Any current immunosuppressive medication/health condition?	☐	☐	
Any vaccinations within the last four weeks?	☐	☐	

Student/employee signature: ..... Date: .....

Before repeat IGRA test

Since your last IGRA test have you had:	**Y**	**N**	*If yes to any of the questions please give dates and details:*
• a cough lasting for more than 3 weeks?	☐	☐	
• weight loss for no obvious reason?	☐	☐	
• a persistent fever?	☐	☐	
• heavy night sweats?	☐	☐	
• fatigue or a general or unusual sense of tiredness?	☐	☐	
• loss of appetite?	☐	☐	
• coughing up blood (haemoptysis)?	☐	☐	
• swollen glands or joints?	☐	☐	
• recurrent/persistent kidney/bladder infections?	☐	☐	
Any current immunosuppressive medication/health condition?	☐	☐	
Any vaccinations within the last four weeks?	☐	☐	

Student/employee signature: ..... Date: .....