Vanderbilt University School of Nursing (VUSN)
Annual Post-Chest X-ray TB Questionnaire

Print Name __________________________________________ Date of Birth ____________________________

Complete and sign below if a chest x-ray was previously submitted to Castle Branch due to a positive TB test. If a Positive result was received for the first time from a recent TB test, a chest x-ray is required. Submit pathology report with clear/normal result from x-ray to your Castle Branch account. Contact your VUSN Program Director and local health department immediately if x-ray is abnormal.

**Required self-reporting and signature:**

**History**

Provide date and result of most recent chest x-ray *(submitted to VUSN via Castle Branch)*: ___/__/____

Result: ☐ Normal ☐ Abnormal

Was TB Treatment required?

☐ Treatment was completed on: ___/__/____  
* ☐ Treatment will be completed on: ___/__/____  
*The treating healthcare provider must sign below.

**TB Risk Assessment**

Have you experienced any of the following symptoms within the past 12-months?

- a. Unplanned weight loss ☐ Yes ☐ No
- b. Night sweats ☐ Yes ☐ No
- c. Fever lasting several weeks ☐ Yes ☐ No
- d. Frequent cough in the absence of a cold or flu ☐ Yes ☐ No
- e. Coughing up blood or blood-streaked sputum ☐ Yes ☐ No
- f. Chest pain or pain in the chest when taking a breath ☐ Yes ☐ No
- g. Shortness of breath/difficulty breathing ☐ Yes ☐ No

My signature below affirms the information provided above is accurate to the best of my knowledge and acknowledges that it is my responsibility to contact my healthcare provider if the symptoms listed above develop. If TB treatment is required, I will immediately inform my VUSN Program Director.

Signature __________________________________________ Date ____________________________

Ask healthcare provider to sign verification statement below:

**Healthcare Provider signature required**

Provider signature below confirms this patient has no signs or symptoms of active TB.

Provider Signature & Credentials __________________________________________ Date ____________________________

Printed Name __________________________________________

Phone __________________________ Fax ____________________________

Address __________________________________________

Revised 2/26/2020