UNIVERSITY OF HAWAIʻI AT MĀNOA
Nancy Atmospera-Walch School of Nursing
Office of Student Services

FORM D

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TUBERCULOSIS MONITORING FORM

Only for students with Positive PPD (induration >= 10 mm)

Student Name: ______________________ UH Email: ______________________

Department: ______________________ Phone: ______________________

1. Date of your last TB skin test (PPD) ______________ Result: ________ mm., if known
2. Date of your last Chest X-ray (CXR) ______________ Result: ☐ normal ☐ not normal, if known

   Where Performed: ____
3. Have you been “exposed” to tuberculosis within the past year? ☐ Yes ☐ No

   If yes, where? ______________________________

   a) in hospital: Patient ______________________ Other ______________________

   b) in community (e.g., family, social activities) ______________________________
4. Have you experienced any of the following symptoms in the last year?

	Yes	No	Comments
Coughing longer than 3 weeks	☐	☐	______________________
Coughing up blood	☐	☐	______________________
Shortness of breath/difficulty breathing	☐	☐	______________________
Chest Pain	☐	☐	______________________
Weight loss/loss of appetite	☐	☐	______________________
Night sweats	☐	☐	______________________
Chills/fever	☐	☐	______________________
Fatigue (more than usual)	☐	☐	______________________

5. Do you have any chronic diseases? ☐ Yes ☐ No. If yes, list:

   ____
6. List all medications you are taking now:

   ____

By signing below, I affirm that all my responses are true and accurate.

______________________________ ______________________________
Student's Signature Date

Remember, wait until you have your positive TB test and CXR documentation before you fill out & sign.

2528 McCarthy Mall, Webster 201, Honolulu, HI 96822
Telephone: (808) 956-8939, Facsimile: (808) 956-5977

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