

**UNIVERSITY OF CALIFORNIA SAN FRANCISCO
SCHOOL OF MEDICINE, GRADUATE MEDICAL EDUCATION**

2022/2023 HEALTH STATEMENT FOR CONTINUING RESIDENTS & FELLOWS

Screening for tuberculosis is required. Both positive and negative TB skin test readings must be recorded in millimeters.

First Name _____ Middle Name _____ Last Name _____

Program _____ Date of Birth _____

BACKGROUND INFORMATION

- Have you traveled internationally/overseas in the past year? Yes No
If yes, where? _____
- Country of birth _____
- Have you worked in a prison or homeless shelter in the past year? Yes No
- Have you entered a TB isolation room without a mask or had an exposure to a known case of TB in the past year? Yes No
- Have you been notified that your immune system is suppressed or compromised? Yes No

NOTE: HIV infection and other medical conditions may cause a TB skin test to be negative even when TB infection is present.

Have you ever received BCG vaccine? Yes No Don't Know
Year of most recent BCG _____ Country _____

SIGN AND SYMPTOM REVIEW

Have you ever had any of the following symptoms for more than three weeks at a time?

(Please check ALL appropriate boxes)

- | | | | |
|-----------------------------|--|-------------------|--|
| Excessive sweating at night | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coughing up blood | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hoarseness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Persistent coughing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Persistent fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Note: Please call CRMC Employee Health at (559) 459-6416 to schedule an appointment if you have checked any of the above symptoms.

IF YOU HAVE A NEGATIVE TB SKIN TEST HISTORY

Screening for Tuberculosis is required annually no later than **April 30th** by the Employee Health Services located at any of our affiliate hospitals (CRMC/VA). It is your responsibility to provide a copy of your results to the Graduate Medical Education department by the **April 30th** deadline for processing.

IF YOU HAVE A POSITIVE TB SKIN TEST HISTORY, COMPLETE THE FOLLOWING

Date of TB skin test conversion: _____ mm Reading: _____

Note: If you have become PPD positive within the past 12 months, you must submit documentation of a chest x-ray taken at the time of conversion.

| | |
|---|---|
| INH Therapy Taken: <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Therapy Taken: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Length of Treatment: _____ mos. | Length of Treatment: _____ mos. |

SIGNATURE: _____ DATE: _____