

**OFFICE OF PROSPECTIVE HEALTH
188 LIFE SCIENCES BUILDING - BRODY SCHOOL OF MEDICINE
INTERVAL HISTORY-HEALTHCARE
744-2070, 744-2417 (FAX)**

Name _____ / Name change? (Previous) _____
Department _____ Job Title _____ Phone _____
Date _____ DOB _____

1. Have you had any change in your health status, which might affect your work?
Yes No If yes, please describe _____
2. Have you developed any chronic illness in the past year which might affect your work or immune system?
Yes No If yes, please describe _____
3. Have you developed any new allergies in the past year?
Yes No If yes, please describe _____
4. Do any work activities cause you physical problems?
Yes No If yes, please describe _____
5. Do you work with lasers? Yes No
6. Are you taking any of the following types of medication (which might affect your susceptibility to infectious diseases)?
 - a. Prednisone or other steroids? Yes No
 - b. Anti cancer drugs? Yes No
 - c. Anti rejection drugs for organ transplant? Yes No
7. Do you experience any symptoms with use of latex gloves, such as rash, hives, wheezing, sneezing or runny nose? Yes No If yes, please describe _____
If yes, are you now using a non-latex glove? Yes No
8. Have you ever had a positive skin test for tuberculosis? Yes No
If yes, do you currently have any of the following symptoms? Fever, night sweats, unexplained weight loss, chronic cough or coughing blood? Yes No

Signature _____

For healthcare providers only:

9. Do you perform any procedures that could induce cough or aerosolize sputum, such as bronchoscopy, transtracheal aspiration, endotracheal intubation or suctioning, emergency dental, endoscopies or autopsy on suspect or known TB patients? Yes No
10. Respiratory Protection Device used: Have you ever been fit tested for TB respiratory mask? Yes No NA
OR Do you use a Powered air purifier respirator, due to beard or inability to get a good fit? Yes No NA
11. Do you have any problems breathing or working while wearing your TB mask or PAPR? Yes No

For Facilities personnel:

12. Have you used your respiratory protection to protect from mold exposure in the past year? Yes No

For mask users only:

12. Since your TB mask was last fitted, have you gained or lost 20 pounds, had surgery on your face or neck or had dentures installed or removed? Yes No Grown a beard? Yes No
13. Do you perform a seal check to ensure a tight seal each time you wear your TB mask? Yes No

Signature _____