结核病风险评估表
校园健康中心

Tuberculosis (TB) Risk Assessment
Campus Health Center

INTERNAL USE ONLY
□ ELI □ OISS □ SA
Insurance:

请用英文填写

Name:_____ **Today's Date:** ____/____/____
LAST FIRST MONTH DATE YEAR

Birth Date: ____/____/____ **Birth Country:**_____
MONTH DATE YEAR

Phone: (____) ____ – ____ **WSU Email:** _____**@wayne.edu**
(2 letters and 4 numbers ex: ab1234@wayne.edu)

Wayne State ID# __ __ __ __ __ __ __ __ __ **Contact By:** □ Phone □ Email

是 Yes	否 No	
□	□	您是否曾经检测出结核病皮肤测试呈阳性？如为阳性结果，是否曾经接受药物治疗？ □ 否 □ 是 治疗了多长时间？_____ **Have you ever had a positive TB skin test? If yes, were you treated with medication?** □ No □ Yes How long? _____
□	□	您是否接种过卡介苗（结核病疫苗）？如果接种过，请注明接种日期：_____ **Have you ever been vaccinated with BCG (TB vaccine)?** If yes, when? _____
□	□	您是否曾出现任何以下症状？ *（请勾选所有适用项）* **Have you had any of these symptoms? *(check all that apply)*** □ 咳嗽超过 3 周 — Cough for longer than 3 weeks □ 慢性发烧 — Chronic fever □ 咳血或痰中带血 — Coughing up blood or blood in sputum □ 夜间盗汗超过 3 周 — Night sweats for longer than 3 weeks □ 不明原因的体重减轻 — Unexplained weight loss
□	□	您最近是否与传染结核病患者（家人、同事、室友等）有密切接触？ **Have you had recent close contact with someone with infectious TB disease (family member, co-worker, roommate, etc.)?**
□	□	您是否曾与 PPD 测试呈阳性的人士住在一起？ **Have you ever lived with someone who has had a positive PPD test?**
□	□	您是否曾经检测出胸部 X 光检查结果异常？ **Have you ever had an abnormal chest x-ray?**
□	□	您是否曾经检测出艾滋病毒或者艾滋病呈阳性？ **Have you tested positive for HIV or AIDS?**

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是 Yes	否 No	
☐	☐	您是否曾经接受器官和／或骨髓移植？ **Have you ever had an organ and/or bone marrow transplant?**
☐	☐	您是否曾经服用会影响您的免疫系统的药物？ **Have you ever taken medications that affect your immune system?**
☐	☐	您是否曾在美国以外的国家／地区连续居住 30 天或者长达 30 天以上？ 如果是，请注明国家／地区及时间。 国家／地区：_____ 年份：_____ **Have you spent 30 or more consecutive days in a country other than the United States?** If yes, where and when? Country: _____ Year: _____
☐	☐	您是否在任何以下机构生活或工作：*（请勾选所有适用项）* **Do you live or work in any of the following settings: *(check all that apply)*** ☐ 惩教所（监狱） Correctional facility (prison) ☐ 长期护理机构 Long term facility ☐ 艾滋病毒／艾滋病感染者居留所 HIV/AIDS residence ☐ 医院 Hospital ☐ 收容所 Homeless shelter ☐ 疗养院 Nursing home ☐ 实验室（请注明类型）：_____ Laboratory (specify type) ☐ 其他健康护理机构 Other health care facility

☐ WAIVED DATE:	IGRA ☐ T-Spot DATE: TIME: ☐ DMC	Chest X-Ray ☐ Referral DATE:

Responsible Provider Initials: _____

March 13, 2015