PURCHASE COLLEGE HEALTH SERVICE
TARGETED TESTING FOR TUBERCULOSIS INFECTION
RISK ASSESSMENT QUESTIONNAIRE (RAQ)

Name: _____ CID#_____
Age____ Date of Birth_____

This questionnaire is given to all students intending to travel internationally for the purpose of determining your need for a skin test for screening for Tuberculosis. Please answer all questions to the best of your ability, and bring the completed form to your scheduled appointment at Health Services

1. In what country were you born? _____
If you were born outside of the USA, when did you move here? _____/_____ (month/year)

2. Have you visited or lived in any countries other than the USA for one month or more?
____NO
____YES Which countries?_____

Did you stay with people who have lived/worked in that country for one month or more?
____No __Yes
Were you studying or working in a health-care, or disaster-relief capacity? ___No ___Yes

3. Have you ever lived, volunteered or worked in a prison or jail, nursing home, hospital or other health-care facility, residential facility for people with AIDS or HIV infection, homeless shelter or drug-treatment facility and had contact with the patients or residents?
____No ____Yes (Where/when/ in what capacity?)_____

4. Will you be working, doing a rotation, or interning in one of the above facilities, or in a microbiology lab in the coming year?
____No ____Yes (Where?)_____

5. Have you ever lived, worked, or been in close contact with a person with active TB, including when you were a child?
____No ____Yes (Where/when?) _____

6. Do you have any of the following conditions? ____No ____Yes

Chronic Renal Failure	Organ transplant recipient
Diabetes	Corticosteroid therapy (Prednisone $\geq$ 15mg/d for at least 1 month.) or other immunosuppressive disorders
Leukemia or lymphomas	
Low body weight or malnutrition	HIV infection or AIDS
Chronic malabsorption syndromes	Receiving immunosuppressive therapy, e.g., Remicade
Gastrectomy and/or jejunoileal by-pass	Injection drug use

All answers are true to the best of my knowledge. I understand that this questionnaire will remain part of my confidential medical record. This information may be released only with my written consent or under subpoena from a court of law.

Signature_____ Date:_____