

Napa Valley College Student Health Center
ANNUAL SYMPTOM REVIEW

Office: 707-256-7780

Name:		Date:	
AKA: N/A		Hire Month: N/A	
Dept: HEOC	Job: N/A	Your Extension: N/A	Manager: N/A

History and Symptom Review

Are you allergic to any medication?	Yes	No
If yes, please list:		
Are you currently taking steroids or other immune suppressants?	Yes	No
Do you have any immune disorder/illnesses (including splenectomy)?	Yes	No
Have you received a vaccine in the past 6 weeks? (Measles, Rubella, Varicella)	Yes	No
Does your department require annual fit testing? If so, please schedule.	Yes	No
Have you ever had a positive skin test for Tuberculosis (TB)?	Yes	No
If yes, when?	Date:	Induration: mm
What medication was it treated with? _____ INH _____ Other	Begin Date:	End Date:
During the past year, have you ever experienced any of the following:		
1) Night Sweats	Yes	No
2) Persistent Coughing	Yes	No
3) Coughing up Blood	Yes	No
4) Unexplained Weight Loss	Yes	No
5) Excessive Fatigue or Tiredness	Yes	No
6) Fever of Unknown Origin	Yes	No

TO BE COMPLETED BY EMPLOYEE HEALTH OR NURSE MANAGER

Symptoms Reviewed by and DATE:	Negative	Positive
Chest X-Ray Date Ordered:		
PPD #1: Date / /	RFA/LEA	By:
PPD Reading Date:	Induration: mm	By:
Need two step PPD? Yes No		
PPD #2: Date / /	RFA/LFA	By:
PPD Reading Date:	Induration: mm	By:
Comments:		
I:EH:Questionnaires Annual		