Napa Valley College Student Health Center

ANNUAL SYMPTOM REVIEW

Office: 707-259-8005 Fax: 259-8031

Name:		Date:	
AKA:		Hire Month:	
Dept:	Job:	Your Extension:	Manager:

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:	**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:Questionaires Annual**		