



Signs and Symptoms Letter

Name: *(Please print)* _____ Date: _____

University ID: _____

It is mandatory that this form be completed and kept in your clinical compliance file if you have a current or prior positive PPD. Please check either “Yes” or “No” to the questions below.

Please place a check (✓) your response.

Night Sweats (not related to heat or hot flashes) Yes No

Fatigue/Tiredness Yes No

Loss of Appetite Yes No

Cough (productive or dry) Yes No

Unexplained Fever Yes No

Weight Loss (unplanned or greater than planned) Yes No

Signature: _____ Date: _____