VAPHS Occupational Health Appointment Date:       Time:

University Drive C (001E-U)

Pittsburgh, PA 15240

 **Preventive Medicine Program for Personnel with Animal Exposure**

**ANNUAL REVIEW FORM**

**Complete and submit to Occupational Health – Mail code 001E-U**

*VAPHS wants to reassure all individuals who have enrolled or are scheduled to enroll in this program, that your medical information will be handled with the strictest confidence and in compliance with the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA). Your personal and Medical information will only be available to those clinical care providers in Occupational Health with a need to know.*

**Please Print or Type:**

Name:       Last Four Social Security **#:**

Department:      VA Mailing Address:

Telephone Number            Date of Birth:      /     /

Male **[ ]**  Female **[ ]**  If female, Pregnant: [ ] Yes [ ] No

Job/Position:           Job Duties:

PI/Supervisor Name & Ext:       IACUC Protocol #           or [ ] NA

**1.** Species contact within VA Pittsburgh Healthcare System (check all that apply):

**[ ]  Dog**

**[ ]**  **Cat**

**[ ]  Non-human primates** (baboon, monkey, etc.), please specify

If working with non-human primates, have you ever been diagnosed with Tuberculosis?

[ ] Yes [ ]  No

If Yes:

Medication taken      Duration of Therapy       Dates of diagnosis and therapy

BCG vaccination [ ] Yes [ ]  No If Yes, give date:

Positive TB tests (Tine, PPD, Mantoux) [ ] Yes [ ]  No If yes, provide history

**[ ]  Sheep, Goats, Pigs, Calves,** please specify

**[ ]  Rodents** (mice, rats, hamster, gerbil, guinea pig, etc.), please specify

**[ ]  Rabbit**

[ ]  **Other**, please list:

**2.** Total number hours of animal contact per week at work (including animal tissues, waste, body fluids, carcasses, or animal housing areas):

**3.** Work involves human pathogens: [ ] Yes [ ]  No

If yes, specify:

**4.** Work involves animal pathogens: [ ] Yes [ ]  No

 If yes, specify:

**5.** Are you receiving immunosuppressive therapy that could increase risk of zoonotic disease? [ ] Yes [ ]  No

**6.** As part of assigned duties, how often do you wear?

Never Rarely Sometimes Always

Gown [ ]  [ ]  [ ]  [ ]

Mask [ ]  [ ]  [ ]  [ ]

Bonnet [ ]  [ ]  [ ]  [ ]

Protective eye wear [ ]  [ ]  [ ]  [ ]

Disposable gloves [ ]  [ ]  [ ]  [ ]

If use gloves, any evidence of latex sensitivity [ ] Yes [ ] No

**7**. How often do you do the following after handling animals during the day?

 Never Rarely Sometimes Always

Wash Hands [ ]  [ ]  [ ]  [ ]

Change clothing [ ]  [ ]  [ ]  [ ]

Shower [ ]  [ ]  [ ]  [ ]

**8.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have, or have you ever had:** | Yes | No |  (if YES) COMMENTS |
|  Allergic rhinitis/conjunctivitis/hay fever |  |  |  |
|  Anaphylaxis |  |  |  |
|  Asthma |  |  |  |
| Chronic cough |  |  |  |
|  Eczema/urticaria/hives |  |  |  |
|  Family history of allergic disease (explain if yes) |  |  |  |

**9.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Prior history of allergic symptoms with animal exposure** | Yes | No | If Yes, **Species** and **Frequency** (never, monthly, weekly, daily) |
|  Itching, tearing or swelling of eyes |  |  |  |
|  Nasal discharge |  |  |  |
|  Coughing |  |  |  |
|  Chest tightness or wheezing |  |  |  |
|  Skin rash or itching |  |  |  |
|  Sneezing spells |  |  |  |
|  Difficulty swallowing |  |  |  |

***\*Employees with suspected work related allergies should seek evaluation and treatment from their physician.***

**10.** Do you have any house pets that could be responsible for allergic symptoms, or could represent a disease transmission hazard to you or the animals in the Animal Research Facility? [ ] Yes [ ] No

If yes, list:

**11.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever suffered from:** | Yes | No | Describe Severity & and Corrective Measures |
|  Inguinal or similar hernia |  |  |       |
|  Back Pain |  |  |       |
|  Joint problems, arthritis |  |  |       |
| **Other chronic health problems:** |
|       |  |  |       |
|       |  |  |       |

**12**. Do you work with Chemicals? [ ] Yes [ ] No

If Yes, describe any symptoms that could be associated with such exposure:

**13.** Do you have any significant health history that might suggest exposure to workplace hazards?

[ ] Yes [ ] No If Yes, describe

**14.** Are you exposed to waste anesthetic gases during your work? [ ] Yes [ ] No

If Yes, Describe

If Yes, has there been any evidence of reproductive, liver, kidney, or blood disorders during the past year?

[ ] Yes [ ] No If Yes, Describe:

**I certify I understand all requests for information on this form and that the information I supplied is correct**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE SIGNATURE and DATE

**15.** Do you wish to receive a medical exam with the submission of this questionnaire?

[ ] Yes [ ] No

If no, you may be contacted by someone in the VAPHS Occupational Health Service if there are any questions concerning the information provided.

**I am declining a Medical Exam with this annual medical review.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE SIGNATURE and DATE

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***For VAPHS Occupational Health Service Use Only*:**

I have reviewed the information provided (Medical Practitioner Signature & Date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization/testing history:

Tuberculin Skin Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] NEG [ ] POS \_\_\_\_\_\_\_\_\_\_\_\_\_ mm

Tetanus-diphtheria Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RABIES 1: \_\_\_\_\_\_\_\_\_\_\_\_\_

RABIES 2: \_\_\_\_\_\_\_\_\_\_\_\_\_

RABIES 3: \_\_\_\_\_\_\_\_\_\_\_\_\_

Bloodborne Pathogen surveillance:

HBV vaccine 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HBV vaccine 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HBV vaccine 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLIO vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_

VZV (Varicella) vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_

Toxoplasmosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exposure to anesthetic gases? **[ ] Yes [ ] No**

If Yes, does review of reproductive history reveal any suspicion of work-related problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, Medical Surveillance will be initiated for exposure to anesthetic gases (which includes baseline CBC, liver profile, renal profile, and medical and reproductive history updates; if NIOSH limits are exceeded in the Animal Research Facility, blood workup will be repeated).

RECOMMENDATIONS/NOTES: