VAPHS Occupational HealthAppointment Date:       Time:

University Drive C (001E-U)

Pittsburgh, PA 15240

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

**HEALTH QUESTIONNAIRE**

**INITIAL EXAM 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

**I.**

**Must be completed by Employee and SUPERVISOR or PRINCIPAL INVESTIGATOR**

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

**Dog**

**Cat**

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

**Sheep, Goats, Pig, Calves,** please specify

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

**Rabbit**

**Other**, please list:

1. Total number hours of animal exposure/contact per week at work:
2. For use with **live animals** only, any work with:

A) **Recombinant DNA** Yes  No

B) **Infectious Agents** Yes  No please list:

C) **Bloodborne Pathogens** Yes  No

D) **Human Cell lines** Yes  No

E) **Very Hazardous Agents** Yes  No please list:

F) **Radiation** Yes  No please list:

G) **Lasers** (Class 3b, 4a) Yes  No please list:

H) **Toxins** Yes  No please list:

I) **Exposure to anesthetic gases Yes  No please list:**

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

**Name and Signature of Supervisor or Principal Investigator** **Date**

**II.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| GENERAL OCCUPATIONAL HISTORY | YES | NO | LATEX HISTORY | YES | NO |
| **A**. Have you ever used protective clothing or equipment? |  |  | **A**. Have you ever had an anaphylactic (severe, life threatening) reaction to latex devices or products? |  |  |
| Respirators (if yes, give type:      ) |  |  | **B**. Have you ever been told by a Doctor that you have an allergy to any latex product?, If yes, specify: |  |  |
| Hearing Protection |  |  | **C**. Were you born with any birth defects or limiting conditions which may predispose to latex sensitivity (spina bifida, Myeloma, myelodysplasia) |  |  |
| Protective suit/isolation gown |  |  | **D**. After handling latex products have you ever experienced any of the following: |  |  |
| Barrier Gloves |  |  | Difficulty breathing |  |  |
| Eye/Face Protection |  |  | Chapping or ‘cracking’ of hands |  |  |
| **B**. At work, have you ever been exposed to, or worked with any of the following types of hazards: |  |  | Runny nose/congestion |  |  |
| Chemotherapeutics |  |  | Itchiness (hands/eyes) |  |  |
| Bloodborne Pathogens |  |  | Redness |  |  |
| Asbestos |  |  | Swelling |  |  |
| Lasers |  |  | Hives |  |  |
| Radiation/Radiology Exposure |  |  | Other: |  |  |
| Mercury/Lead/Cadmium (i.e. heavy metals) |  |  | **E**. Have you had an allergic reaction to any of the following: |  |  |
| Other Materials? |  |  | Avocados/bananas/chestnuts/kiwis/papaya/peaches/potatoes |  |  |
|  |  |  | Baby bottles/nipples/balloons/erasers |  |  |
| INFECTIOUS DISEASE: Tuberculosis: |  |  | Elastic waistbands/elastic bandages |  |  |
| Have you, or anyone in your family ever had Tuberculosis/TB? |  |  | Face masks/foam pillows |  |  |
| Have you ever had a TB skin test? Date of most recent test: |  |  | Hot water bottles/ostomy bags/ condoms |  |  |
| Have you ever had a reaction to the TB skin test? |  |  | Rubber bands/rubber gloves/rubber grips |  |  |
| IF yes, were you treated with INH?  Date of last chest X-ray: |  |  | Other |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Do you work with, or have you been immunized against any of the following: | Work With | Immunized | Date(s) of Immunization |  | Do you work with or are exposed to Anesthetic Gases? | YES | NO |
| Botulinum |  |  |  |  | If yes, is there any prior history of any of these medical problems: | | |
| Vaccinia |  |  |  |  |
| Q Fever |  |  |  |  | Reproductive problems or disorders for you or your spouse? |  |  |
| Rabies virus |  |  |  |  |
| Measles Virus |  |  |  |  |
| Human Retroviruses |  |  |  |  |
| Meningococcus |  |  |  |  | Liver Disorders |  |  |
| Tetanus Diphtheria (Td) |  |  |  |  | Kidney Disorders |  |  |
| Other: |  |  |  |  | Hematological/blood disorders |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have, or have you ever had: | Yes | No | COMMENTS (if YES) |
| Allergic rhinitis/conjunctivitis/hay fever |  |  |  |
| Anaphylaxis |  |  |  |
| Asthma |  |  |  |
| Chronic cough |  |  |  |
| Eczema/urticaria/hives |  |  |  |
| Family history of allergic disease (explain if yes) |  |  |  |
| Prior history of allergic symptoms with animal exposure |  |  |  |
| Itching, tearing or swelling of eyes |  |  |  |
| Nasal discharge |  |  |  |
| Coughing |  |  |  |
| Chest tightness or wheezing |  |  |  |
| Skin rash or itching |  |  |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Skin Diseases |  |  |  |
| Diabetes |  |  |  |
| Seizure disorder |  |  |  |
| Back Pain |  |  |  |
| Color blindness |  |  |  |
| Other: |  |  |  |

**III.**

1. Have you ever contracted an occupational illness, or had a serious injury from an animal or in animal-related work? Yes No If yes, please explain in detail.
2. Have you had a splenectomy? Yes No

Are you on any immunosuppressant drugs? Yes No

1. Please note any other current health problems/history you consider significant:

D. Are you being treated by a physician for a health problem? Yes No (If yes, list):

E. Are you currently taking any medications (Over the Counter or Prescribed)? Yes No (If yes, list):

F. Do you have any allergies to medication? Yes No (If yes, list):

G. Do you have any work restrictions or physical limitations? Yes No (If yes, list):

H. Do you require any work accommodations for the position for which you are applying or presently performing? Yes No (If yes, list):

1. List all hospitalizations and surgeries with approximate dates:

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

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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: