VAPHS Occupational Health
University Drive C (001E-U)
Pittsburgh, PA 15240

Appointment Date: ______ Time: ______

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

****

***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: