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

Appointment Date: _____ Time: _____

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: _____

2. Total number hours of animal exposure/contact per week at work: _____

3. 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.

A. 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. _____

B. Have you had a splenectomy? ☐Yes ☐No
Are you on any immunosuppressant drugs? ☐Yes ☐No

C. 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):_____

I. List all hospitalizations and surgeries with approximate dates:
   a. _____
   b. _____
   c. _____

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

_____
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: