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

Appointment Date: _____ Time: _____

NON-RESEARCH VAPHS PERSONNEL

Occupational Health and Safety Questionnaire
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:_____ Mailing Address: _____

Telephone Number _____ Date of Birth: _____/_____/_____

Male ☐ Female ☐ If female, Pregnant: ☐Yes ☐No or ☐NA

Position:_____

Species that are housed in the VAPHS Animal Research Facility:

- Rodents (mice, rats)
- Rabbits

1.

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)			

2.

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.

3. 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:_____

4. 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 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):_____

RECOMMENDATIONS/NOTES: