

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

Appointment Date: \_\_\_\_\_

Time: \_\_\_\_\_

## VETERINARIANS and NON-AFFILIATED MEMBERS of the IACUC

### 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: \_\_\_\_\_

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

**Dog**

**Cat**

**Nonhuman primate** (baboon, monkey, etc.), please specify \_\_\_\_\_

If working with 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.

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)			

4.

Prior history of allergic symptoms with animal exposure	Yes	No	If Yes, <u>Species</u> and <u>Frequency</u> (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.*

5. 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: \_\_\_\_\_

6. 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

\*\*\*\*\*

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

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

RECOMMENDATIONS/NOTES: