

**Medical Questionnaire Form for Animal Exposure
Risk Assessment**

Date: _____

I. Biographical Information:

Name: _____ Date of Birth: _____

Sex (circle): Male Female

Principal Investigator (if applicable): _____

Department: _____

Campus Mailing Address: _____

Campus Phone: _____ Home Phone: _____

II. Species Contact and Animal Allergies:

1. Check Species with which you expect to have contact
2. Check the appropriate frequency of contact with each species

	<u>Daily</u>	<u>1-4 Times Week</u>	<u>1-3 Times Per Month</u>	<u>Infrequent, Once Per Month</u>
<input type="checkbox"/> Mice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sheep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reptiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Goats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rabbits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Swine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Birds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Guinea Pigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Amphibians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hamsters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gerbils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic to any animals (circle)? Yes No

If yes, please note animals and symptoms below:

Have you had any of the following symptoms that you feel are caused or worsened due to working with research animals?

Watery, burning, or itchy eyes? Yes No

Runny Nose? Yes No

Sneezing? Yes No

Wheezing? Yes No

Cough? Yes No

Shortness of breath? Yes No

Chest tightness? Yes No

Hives? Yes No

Rash? Yes No

III. Medical History:

Have you ever been diagnosed with the following:

Asthma? Yes No

Allergic Rhinitis?
(runny nose due to allergy) Yes No

Allergic Conjunctivitis?
(itchy, watery eyes due to allergy) Yes No

Do you have a History of:

Hayfever? Yes No

Parent or sibling with allergies
to animals or their substances? Yes No

Have you ever had a positive allergy skin test? Yes No

If yes, how many positive skin tests to non-animal antigens have you had? _____

If yes, how many positive skin tests to animal antigens have you had? _____

Have you ever been bitten by a lab animal? Yes No

If yes, how many times? _____

Have you ever injured yourself or become ill while working with or around lab animals or animal facilities? Yes No

If yes, indicate the nature of the injuries (check all that apply):

Animal scratch Animal type? _____

Muscle strain or sprain

Needle stick or scalpel injury

Cut on animal cage/equipment

Infection from animal

If working with large animals, please answer the following questions:

Do you anticipate working with live goats, sheep or their tissues? Yes No

If yes, answer the following:

Do you have heart valve disease? Yes No

Do you have a birth defect involving your heart? Yes No

Do you have an immune deficiency? Yes No

IV. Other Pertinent Medical Information:

Do you take immunosuppressive drugs? Yes No

Have you ever had a tetanus shot? Yes No

Date of last tetanus shot _____

Do you smoke cigarettes? Yes No

If yes, how many packs per day? _____

How many years have you smoked? _____

Answer if you are Female:

Are you pregnant? Yes No

Are you physically capable of becoming pregnant? Yes No

V. Environmental Risk Factors:

In your work do you:

Lift more than 20 pounds (10 kg) on a regular basis? Yes No

Use noise generating equipment? Yes No

If yes, do you use ear protection? Yes No

Use a respirator mask? Yes No

If yes, was it fitted by Environmental Health Services Staff? Yes No

Do you have any workplace health concerns not covered by this questionnaire that you like to discuss with the occupational healthcare specialist?

Signature: _____

Please return questionnaire to:
Jane Kavan
Associate Director of Research Compliance
Department of Research Compliance