Marshall University
Occupational Health

ANNUAL REVIEW FORM

Animal Exposure Preventive Medicine Program
Health Questionnaire

Marshall University reassures 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: _____ MU ID **#:**_____

Department:_____ MU Mailing Address: _____

Telephone Number _____Date of Birth: _____/_____/_____ Male ☐ Female ☐
If female, Pregnant: ☐Yes ☐No

Job/Position:_____ **IACUC Protocol #** _____ or ☐NA

1. Species contact within Animal Resource Facility (check all that apply):
- ☐ **Rodents** (Mice [M], Rats [R], Hamster [H], Gerbil [G], Guinea Pig [GP], etc.), please specify_____
- ☐ **Rabbits**
- ☐ **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
Disposable gloves,	☐	☐	☐	☐
If use gloves, any evidence of latex sensitivity ☐No ☐Yes				
Gown	☐	☐	☐	☐
Mask,	☐	☐	☐	☐
Cap	☐	☐	☐	☐
Protective eye wear	☐	☐	☐	☐

7. Do you smoke, eat, or drink in animal holding or procedure areas? No ☐ Yes ☐

8. How often do you do the following after handling animals during the day:

	Never	Rarely	Sometimes	Always
Wash hands	☐	☐	☐	☐
Change clothing	☐	☐	☐	☐
Shower	☐	☐	☐	☐

9.

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)			

10.

Prior history of allergic symptoms with animal exposure	Yes	No	If Yes, **Species** **Frequency** (never, monthly, weekly, daily)
Itching, tearing or swelling of eyes			
Nasal discharge			
Coughing			
Chest tightness, shortness of breath, or wheezing			
Skin rash, hives, or itching			
Sneezing spells			
Difficulty swallowing			

(*Employees with suspected work related allergies should seek evaluation and treatment from their physician.)*

11. 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 Resource Facility? ☐No ☐Yes. If yes, list:_____

12.

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:			
_____			_____
_____			_____
_____			_____

13. Do you work with Chemicals? ☐No ☐Yes. If Yes, describe any symptoms that could be associated with such exposure: _____

14. Do you have any significant health history that might be affected by exposure to workplace hazards?
☐No ☐Yes. If Yes, describe _____

15. Are you exposed to waste anesthetic gases during your work?
☐No ☐Yes. If Yes, list gas exposed to _____
If YES, has there been any evidence of Reproductive, Liver, Kidney, or Blood disorders during the past year? ☐No ☐Yes. If Yes, Describe: _____

I certify that the information I supplied is correct or waive participation below.

_____
EMPLOYEE SIGNATURE and DATE

Waiver – Important: Non-participation in an Occupational Health Program can result in adverse health effects.

At this time, I decline to participate in the Occupational Health Questionnaire for persons having contact with animals.

_____
Signature Date

I wish to have my personal physician administer my Occupational Health Program.

_____
Signature Date

***For Marshall University Occupational Health Use Only*:**

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

Immunization/testing history:

DATE (or NA) DATE

Tuberculin Skin Test _____ ☐NEG ☐POS _____ mm

Tetanus-diphtheria Vaccine _____ RABIES 1: _____
RABIES 2: _____
RABIES 3: _____

Bloodborne Pathogen surveillance
HBV vaccine 1: _____ POLIO vaccine _____
HBV vaccine 2: _____
HBV vaccine 3: _____ VZV vaccine _____
_____ (Varicella)
TOXOPLASMOSIS _____
☐**No** ☐**Yes** Exposure to anesthetic gases.

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).

NOTES/ RECOMMENDATIONS: