Occupational and Medical History for Research Animal Contact

Name: ________________________________

Title: ________________________________

The above employee has completed the Occupational and Medical History for Research Animal Contact Form. The form was reviewed by a Licensed Health Care Provider.

Licensed Health Care Provider

Follow-Up Required ☐ Yes ☐ No

Cleared ☐ Yes ☐ No

Date
Medical Surveillance Program

Exposure Profile

Designed for Persons Working with Animals at the University

GOALS

The following information is designed to help you assess your own risk and avoid potential health problems associated with animal exposure and potential hazard exposure.

This questionnaire is designed to detect early symptoms of illness due to animal and hazard exposures and provide medical consultation. Based on the information, you may be contacted by Occupational Medicine for further follow-up.

Name:_________________________________
Title:___________________________________
Department:_____________________________
Rocket #:__________________________
Date of Birth:__________________________

Name & signature of Licensed Health Care Provider:______________________________  Date:__________________________

Occupational and Medical History for Research Animal Contact
Confidential

1. Please check all animal species that you work with:
☐ Rats     ☐ Rabbits     ☐ Hamsters
☐ Mice     ☐ Amphibians    ☐ Dogs
☐ Fish     ☐ Reptiles     ☐ Cats
☐ Swine     ☐ Guinea Pigs    ☐ Field Caught

2. Have you ever developed any symptoms, illnesses or infections as a result of animal work? ☐ Yes ☐ No

3. Have you ever been told by a physician that you have allergies? ☐ Yes ☐ No

4. Are you on any medications? Please list.
__________________________  __________________________
__________________________  __________________________

5. Do you regularly have any of the following symptoms?
☐ Itching/tearing eyes ☐ Wheezing
☐ Positive TB skin test ☐ Chest tightness
☐ Stuffy/running nose ☐ Shortness of breath
☐ Sneezing ☐ Asthma
☐ Skin rash/hives ☐ Recurrent cough
☐ Immune deficiency, cancer or steroid use

6. If you had any of the symptoms listed above or any history of allergies in the past, have these worsened in the past year? ☐ Yes ☐ No

7. Do you have any health and safety concerns for which you would like to receive more information? ☐ Yes ☐ No

Please indicate the information desired:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

8. Signature and date completed:
Signature:__________________________________________
Today’s Date:______________________________________

The section below is to be completed by a Licensed Health Care Provider.

Follow-Up Required ☐ No ☐ Yes. Date Notified:__________
Comments:_________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Name & signature of Licensed Health Care Provider:______________________________  Date:__________________________

Occupational Health Screening Nurse Tasks
1) Fax page 1 only to Health & Safety at 419-530-3606
2) Scan form & upload to ohm. Verify uploaded then shred