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 ________________________

Date ________________________
Medical Surveillance Program

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