**Instructions for Enrollment**

1. Complete this Animal Exposure Surveillance Program Health Questionnaire and Submit via **one** of the following below:
2. **FAX:** 412-647-5051
3. **Deliver:** *My*Health@Work for the University of Pittsburgh- Employee Health Services Clinic,

 3708 Fifth Avenue, **Medical Arts Building, Suite 505**, Pittsburgh, PA 15213

 between 7:00 a.m. and 3:30 p.m. Monday through Friday.

1. **Email:** the completed Questionnaire to the *My*Health@Work staff at: myhealthatworkpitt@upmc.edu
2. **Do NOT send the completed form via campus mail.**
3. **Do NOT send the completed form to your supervisor.**
4. **Do NOT send the completed form to the Department of Environmental Health and Safety.**
5. **Do Not send photos of completed form (scans only)**
6. **Do Not put a campus address on form**
7. **Please complete entire form**

All information collected by this University of Pittsburgh program will be handled with the strictest confidence and in compliance with all applicable regulations. Your personal and medical information will only be available to those clinical care providers in Employee Health Services with a need to know.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employer and other entities covered by GINA Title II from requesting genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individuals’ family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

|  |
| --- |
| **Demographics** |
| **Name:** |   |   |   |   |   |   |   |   | **Date:** |  |  |   |   |   |
| **SSN:** |   |   |   |   |   |   |   |   | **Pitt ID:** | **2P** |  |   |   |   |
| **Date of Birth:** |   |   |   |   |   |   |   | **Job Position:** |  |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Gender (circle one):** | Male |  | Female |  | **Department:** |  |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
|  **Address:** |   |   |   |   |   |   |   | **Work Email:** |  |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **City/State/Zip:** |   |   |   |   |   |   |   | **Work Phone:** |  |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
|  **Cell Phone:** |   |   |   |   |   |   |   | **Supervisor/PI:** |  |   |   |   |
|  |   |   |   |   |   |   |   |   |  |  |  |   |   |   |
| **Occupational Review** |
| **What are your job duties?**  |   |   |   |   |   |   |   |   |   |   |   |   |
|  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Have you ever had an occupational illness or job injury?** |  |  |  |  | Yes | No |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| ***Please indicate all species of animals that you will be* working *with or will be listed on a protocol for:*** |  |  |
| **Check all that apply** | **Yes** | **No** | ***Check all that apply*** | **Yes** | **No** |
| Rodents |  |  | Macaques--Rhesus, Cynomolgus |  |  |
| Mice/Rats/Hamsters/Gerbils/Guinea Pigs **(Circle)** |  |  | Baboons |  |  |
| Prairie Dogs |  |  | Farm Animals |  |  |
| Rabbits |  |  | Sheep/Goats/Swine **(Circle)** |  |  |
| Ferrets |  |  | Dogs |  |  |
| Fish/Frogs/Turtles **(Circle)** |  |  | Cats |  |  |
| Non-Human Primates |  |  | Tissue Handler: Human/Animal **(Circle)** |  |  |
| New world monkeys--squirrel monkeys |  |  | Other: |  |  |
| **TB** |
| **Have you ever had a TB Skin Test?**  |  |  |  |  |  |  |  |  |  | Yes | No |
| If YES: Date of last TB Skin Test: |  |  |  |  | Month: |   | Year: |   |  |   |
|  |  |  |  |  |  |  |  |
| **Have you ever had a reaction to the TB Skin Test?** |  |  |  |  |  | Yes | No |
| If YES: Were you treated with medication? |  |  |  |  |  |  |  | Yes | No |
| Date of last chest X-Ray: |  |  |  |  |  | Month: |   | Year: |   |  |   |
|  |  |  |  |  |  |
| **Have you or anyone in your family ever had TB/Tuberculosis?** |  |  |  | Yes | No |
|  |  |  |  |  |  |  |  |  |  |
| **Do you have any of the following symptoms:** |  |  |  |  |  |  |  |  |   |
| Unexplained fever or chills |  |  |  |  |  |  |  |  |  |  | Yes | No |
| Unexplained weight loss or night sweats |  |  |  |  |  |  |  | Yes | No |
| Productive cough or blood tinged sputum |   |   |   |   |   |   |   | Yes | No |
| **Infectious Disease Review** |
| **Please indicate if you have a history of an immunization (I) or have/will work with (W) any of the following?**   |
| **Check all that apply** | **I** | **W** | **Check all that apply** | **I** | **W** |
| Anthrax |  |  | HIV | NA |  |
| Avian Flu | NA |  | Influenza Viruses |  |  |
| Botulinum |  |  | Human Retroviruses | NA |  |
| Brucella | NA |  | Japanese Encephalitis |  |  |
| Burkholderia Mallei | NA |  | Malaria | NA |  |
| Burkholderia Pseudomallei (Meliodisis) | NA |  | Orthopox viruses (Monkey pox) |  |  |
| Chikungunya | NA |  | Rift Valley Fever Virus | NA |  |
| Dengue | NA |  | SARS | NA |  |
| Eastern Equine Encephalitis | NA |  | Toxoplasma Gondi | NA |  |
| Francisella Tularemia | NA |  | Vaccinia |  |  |
| Hepatitis A |  |  | West Nile Virus | NA |  |
| Hepatitis B |  |  | Yellow Fever Virus |  |  |
| Hepatitis C | NA |  | Yersinia Pestis (Plague) | NA |  |
| Rabies  |  |  | Other: |  |  |
| **General Occupational Review** |
| **Have you ever used protective clothing or equipment at work?** |  |  |  | Yes | No |
| Ear/Hearing Protection | Yes | No | Other: |   |   |   |   |   |
| Eye Protection | Yes | No |   |  |  |  |  |   |
| Respirators | Yes | No |  |  |  |  |  |   |
| Type: |  |  |  |  |  |   |
|   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Have you ever had exposure to the following at work?** |  |  |  |  |  |   |
| Anesthetic Gases | Yes | No | Lasers | Yes | No |
| Blood Borne Pathogen | Yes | No | Radio-Isotopes/ Radiation Exposures | Yes | No |
| Chemotherapeutic Agents | Yes | No | Infectious Diseases | Yes | No |
| Please Clarify Any: | Please clarify Any: |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Do you have prior history of working with animals?** |  |  |  |  |  | Yes | No |
| If YES: How long did you work with animals? |  |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| When? |  |  |  |  |  |  | Month/Year: |   | to | Month/Year: |   |   |
| If YES: Which species did you work with? |  |  |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
| If YES: What type of work environment? |  |  |  |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
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| **Medical History** |
| **Do you now, or have you ever had:** |  |  |  |  |  |  |  |  |  |  |   |
| Agammaglobulinemia |  |  |  |  |  |  |  |  |  |  | Yes | No |
| Anaphylaxis |  |  |  |  |  |  |  |  |  |  |  | Yes | No |
| Asthma |  |  |  |  |  |  |  |  |  |  |  |  | Yes | No |
| If YES: When? |  |  |  |  |  |  |   |   |   |   |   |   |   |
| If YES: What triggered the asthma? |  |  |  |  |   |   |   |   |   |   |   |
| Cancer |  |  |  |  |  |  |  |  |  |  |  |  | Yes | No |
| Diabetes |  |  |  |  |  |  |  |  |  |  |  | Yes | No |
| If YES: Date of diagnosis? |  |  |  |  |  |   |   |   |   |   |   |   |
| If YES: Do you take any medications? |  |  |  |  |  |  |  |  | Yes | No |
| If YES: Which medications and how often? |  |  |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
| Eczema/Urticarial/Hives/Skin Disease |  |  |  |  |  |  |  |  | Yes | No |
| If YES: Where was/is the skin irritation located? |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
| If YES: What medication/cream is used and how often? |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
| Hay Fever |  |  |  |  |  |  |  |  |  |  |  | Yes | No |
| If YES: What medication/cream is used and how often? |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
| Leukemia |  |  |  |  |  |  |  |  |  |  |  | Yes | No |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Do you now, or have you ever taken any asthma related medications?** |  |  |  | Yes | No |
| If YES: Which medications and how often? |  |  |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Allergy History** |
| **Do you have prior history of allergic symptoms with animal exposures? If so, to what animal(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  |  Yes  | No |
| **If YES:** Which of the following symptoms have you experienced: |  |  |  |   |
| Chest tightness or wheezing |  |  |  |  |  |  |  |  | Yes | No |
| Coughing |  |  |  |  |  |  |  |  |  | Yes | No |
| Itching/Tearing/Swelling of Eyes |  |  |  |  |  |  |  | Yes | No |
| Nasal Discharge/Stuffiness |  |  |  |  |  |  |  |  | Yes | No |
| Sneezing |  |  |  |  |  |  |  |  |  |  | Yes | No |
| If YES: Have you used any medications to control allergy symptoms? |  |  | Yes | No |
| If YES: Which medications and how often? |  |  |   |   |   |   |    |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|   |  |  |  |  |  |  |  |   |   |   |   |    |   |
| If YES: Was the medication effective in controlling your symptoms? |  |  | Yes | No |
| If YES: Have you used any protective equipment (mask, gloves, etc.) to  control allergy exposure/symptoms?If YES: Was the protective equipment effective in controlling your symptoms? | Yes | No |
|   Yes | No |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Allergy History (continued)** |
| **Have you ever had any allergy testing completed?** |  |  |  |  |  | Yes | No |
| **If YES:** When? |  |  |  |  |  |  |   |   |   |   |   |   |   |
| **If YES:** Was it positive? |  |  |  |  |  |  |  |  |  |  | Yes | No |
| **If POSITIVE**: What was it positive for? |  |  |  |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Have you ever taken any allergy injections?** |  |  |  |  |  |  |  | Yes | No |
| If YES: When, and were they effective? |  |  |  |  |  |  |  |  |  |   |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Have you ever had a severe reaction to latex devices or products?** |  |  |  | Yes | No |
| If YES: Under what circumstances did it occur? |   |   |   |   |   |   |   |
|   |  |  |   |   |   |   |   |   |   |   |   |   |   |   |
|   |  |  |   |   |   |   |   |   |   |   |   |   |   |   |
| **Have you ever been told by a doctor that you have an allergy to latex?** |  |  | Yes | No |
| If YES: To what product did the doctor say you were allergic? |   |   |   |   |   |
|   |  |  |   |   |   |   |   |   |   |   |   |   |   |   |
| **After handling latex products, have you ever experienced any of the following:** |  |  |   |
| Difficulty breathing |  |  |  |  |  |  |  |  |  |  | Yes | No |
| Chapped or "cracking" of hands |  |  |  |  |  |  |  |  |  | Yes | No |
| Itching, redness and/or swelling (hands, eyes) |  |  |  |  |  | Yes | No |
| Hives |   |   |   |   |   |   |   |   |   |   |   |   | Yes | No |
| **General History** |
| **Do you have animals at home?** |  |  |  |  |  | Yes | No |
| If YES: Which kind of animal? |  |  |  |  |   |   |   |   |   |   |   |
| If YES: Do they currently reside with you?  |  |  |  |  |  |  |  | Yes | No |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Have you traveled outside the US within the last year?** |  |  |  |  | Yes | No |
| If YES: To which country? |   |   |   |   |   |   |   |   |   |   |   |   |
| If YES: Have you had any health issues since returning? |  |  |  |  | Yes | No |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Have you received a Tetanus Booster in the past 10 years?** |  |  |  |  | Yes | No |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
|  |   |   |   |   |   |   |  |
|  |
|  |
| **General History (continued)** |
| **Do you have any other health problems?** |  |  |  |  |  |  |  |  | Yes | No |
| If YES: Please list: |   |   |   |   |   |   |   |   |   |   |   |   |
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| **Are you taking any other medications?** |  |  |  |  |  |  |  |  | Yes | No |
| If YES: Please list: |   |   |   |   |   |   |   |   |   |   |   |   |
|   |  |  |   |   |   |   |   |   |   |   |   |   |   |   |
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| **I certify that I fully understand all request for information contained on this form and I certify that the information supplied by me on this form is complete and correct to the best of my knowledge.**  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Signature:**  |   |   |   |   |   |   |   | **Date:** |  |   |   |   |   |
|  |   |   |   |   |   |   |   |   |  |  |   |   |   |   |
| ***My*Health@Work *STAFF* ONLY** |
| **I have reviewed the information provided.** |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |
| **Signature:** |   |   |   |   |   |   |   | **Date:** |  |   |   |   |   |
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