University of Pittsburgh Animal Exposure Surveillance Program (AESP)
Health Questionnaire 2019

Instructions for Enrollment

1. Complete this Animal Exposure Surveillance Program Health Questionnaire and Submit via **one** of the following below:

    1. **FAX:** 412-647-5051
    2. **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.
    3. **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.

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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

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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? _____

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? Yes No

If YES: Was the protective equipment effective in controlling your symptoms? 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:

Are you taking any other medications? Yes No

If YES: Please list:

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:** _____