

University of Pittsburgh Animal Exposure Surveillance Program (AESP) Health Questionnaire 2018

Instructions for Enrollment

1. To initiate enrollment, call University of Pittsburgh Employee Health Services at 412-647-4949
2. Complete this Animal Exposure Surveillance Program Health Questionnaire.
3. **FAX:** 412-647-5051
4. Deliver: Enrollment in the Animal Exposure Surveillance Program is completed at the 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.
Email: the completed Questionnaire to Jamie L. Bender MSN, CRNP, FNP-C benderj4@upmc.edu
5. Do NOT send the completed form via campus mail.
6. Do NOT send the completed form to your supervisor.
7. Do NOT send the completed form to the Department of Environmental Health and Safety.

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: _____			
Home Address: _____		Work Email: _____			
City/State/Zip: _____		Work Phone: _____			
Home 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 may be working with on your current job:					
Rodents	Yes	No	Macaques--Rhesus, Cynomolgus	Yes	No
Mice/Rats/Hamsters/ Gerbils/Guinea Pigs	Yes	No	Baboons	Yes	No
Prairie Dogs	Yes	No	Farm Animals	Yes	No
Rabbits	Yes	No	Sheep/Goats/Swine	Yes	No
Ferrets	Yes	No	Dogs	Yes	No
Fish/Frogs/Turtles	Yes	No	Cats	Yes	No
Non-Human Primates	Yes	No	Other:		
New world monkeys--squirrel monkeys	Yes	No			
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					
Do you work with, or have you been immunized against any of the following:					
Anthrax	Yes	No	HIV	Yes	No
Avian Flu	Yes	No	H1N1	Yes	No
Botulinum	Yes	No	Human Retroviruses	Yes	No
Brucella	Yes	No	Japanese Encephalitis	Yes	No
Burkholderia Mallei	Yes	No	Malaria	Yes	No
Burkholderia Pseudomallei (Meliodiosis)	Yes	No	Monkey Pox	Yes	No
Chikungunya	Yes	No	Rift Valley Fever Virus	Yes	No
Dengue	Yes	No	SARS	Yes	No
Eastern Equine Encephalitis	Yes	No	Toxoplasma Gondi	Yes	No
Francisella Tularemia	Yes	No	Vaccinia	Yes	No
Hepatitis A	Yes	No	West Nile Virus	Yes	No
Hepatitis B	Yes	No	Yellow Fever Virus	Yes	No
Hepatitis C	Yes	No	Yersinia Pestis (Plague)	Yes	No
General Occupational Review					
Have you ever used protective clothing or equipment at work?					
	Yes	No		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			
Do you have prior history of working with animals:					
If YES: How long did you work with animals?				Yes	No
When?					
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?	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

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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 now or have you ever had animals at home?	Yes No
If YES: Which kind of animal? _____	
If YES: Did you have any reaction to them? _____	Yes No
If REACTION: What symptoms? _____	
If REACTION: Do you take any medications related to the reaction? _____	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
Have you ever received a Rabies Vaccination?	Yes No

