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

EH&S wants to assure all individuals enrolling in this Program, that your medical information 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.

Instructions For Enrollment

1. To initiate enrollment, call Dr. Yolanda Lang of Employee Health Services at 412-647-3407.

2. Complete this Animal Exposure Surveillance Program Health Questionnaire. Fax the completed Questionnaire to Employee Health at 412-647-1993, or give it to the Clinic worker at the time of the assessment in Employee Health. Do NOT send the completed form via campus mail. Do NOT send the completed form to your supervisor or to the Department of Environmental Health and Safety.

3. Enrollment in the Animal Exposure Surveillance Program is typically completed at the Employee Health Services Clinic, 3708 Fifth Ave., Medical Arts Building, Suite 500.59, Pittsburgh, PA 15213 between 7:30 am and 3:00pm Monday through Friday.

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Name	Date
Social Security No	What is your position? (or position you are applying for?)
Pitt ID No	Job/Position: ____
Date of Birth	Department: ____
Gender (circle one) MALE FEMALE	Department Supervisor/Primary Investigator/Manager (if known)
Address ____	____
City/State/Zip Code ______________________________________	
Home Phone _____(________)______________________________	Work Phone: __(________)__________________________________

NOTE: If you do not know the answer to a question, or do not wish to answer any particular questions, please discuss those questions with the staff at the time of the evaluation.

OCCUPATIONAL REVIEW

GENERAL OCCUPATIONAL REVIEW	YES	NO	GENERAL OCCUPATIONAL REVIEW (Cont)	YES	NO
1. What are your job duties?			B. Rabbits		
			C. Carnivores		
2. Have you ever had an occupational illness or job injury?			Ferrets		
If "YES", please describe:			Fish		
			Frogs		
			Turtles		
			D. Non-human primates		
			New World monkeys (i.e. squirrel monkeys)		
3. Please indicate all species of animals that you may be working with on your current job			Macaques (i.e. Rhesus, Cynomolgus monkeys)		
A. Rodents			Baboons		
Mice			E. Farm Animals		
Hamsters			Sheep or goats		
Gerbils			Swine		
Rats			F. Cats		
Guinea Pigs			G. Dogs		
Prairie Dogs			H. Other animal species (please list)		

GENERAL OCCUPATIONAL REVIEW (Cont)	YES	NO	LATEX HISTORY	YES	NO
A. Have you ever used protective clothing or Equipment?			1. Have you ever had an anaphylactic (severe, life threatening) reaction to latex devices or products?		
Respirators (If YES, list type)			2. Have you ever been told by a doctor that you have an allergy to any latex product? If yes, to what product did the doctor say you were allergic to?		
Ear muffs/plugs/hearing protection					
Protective suit/Isolation gown			3. Were you born with any birth defects or limiting conditions which may predispose you to latex sensitivity (spina bifida, myeloma, myelodysplasia)		
Barrier gloves					
Eye protection			4. After handling latex products have you ever experienced the following:		
B. In the work environment, have you ever been exposed to, or worked with any of the following chemicals?			Difficulty breathing		
			Chapping or "cracking" of hands		
Chemotherapeutics			Runny nose/congestion		
Bloodborne Pathogen Exposure(s)			Itchiness (hands/eyes)		
Asbestos			Redness		
Anesthetic Gases			Swelling		
Lasers (i.e. operating room)			Hives		
Radiation/Radiology Exposure			Other?		
Mercury / Lead / Cadmium (i.e. heavy metals)			5. Have you ever had an allergic reaction to any of the following:		
Excessive Noise			Avocados/Bananas/Chestnuts/Kiwis/Papaya/ Peaches/Potatoes		
INFECTIOUS DISEASES Have you ever had any of these infectious diseases?	**YES**	**NO**	Baby bottles/nipples/ balloons/erasers		
1. Tuberculosis			Elastic waistbands/elastic bandages		
A. Have you , or anyone in your family ever had TB/Tuberculosis?			Face masks/foam pillows		
B. Have you ever had a TB Skin Test? Last TB Skin Test Date: ______/______/________			Hot water bottles/ostomy bags/ latex birth control condom devices (condom)		
C. Have you ever had a reaction to the TB Skin Test?			Rubber bands/rubber gloves/rubber grips		
D. If you had a reaction, were you treated with (INH)? Date of last chest x-ray: ______/______/_______			Other?		

Do you work with or have you been immunized against any of the following:	Work With	Immunized
Botulinum		
Vaccinia		
Q Fever		
Rabies Virus		
Measles Virus		
Human Retroviruses		
Meningococcus		
Radio-isotopes		
Chemotherapeutic agents		
Other		

COMMENTS:

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MEDICAL HISTORY - PART 1	YES	NO
Do you have, or have you ever had: *(If YES to any of the following, please explain in the comment section)*		
1. Allergic rhinitis/conjunctivitis/hay fever		
2. Anaphylaxis		
3. Asthma		
4. Chronic cough		
5. Eczema/urticaria/hives		
6. Family history of allergic disease (please explain)		
7. Prior history of allergic symptoms with animal exposure		
Itching, tearing or swelling of eyes		
Nasal discharge		
Coughing		
Chest tightness or wheezing		
Skin rash or itching		
8. Skin Diseases		
9. Diabetes		
10. Seizure Disorder		
11. Back Pain		
12. Color Blindness		
13. Weakened Immune System		
14. Recent Foreign Travel		
15. Other		

MEDICAL HISTORY – PART 1 (cont.)	YES	NO
COMMENTS:		

MEDICAL HISTORY – PART 2	YES	NO
1. A. Do you have any current health problems?		
B. Are you treating with a physician for a health problem? *If "YES", list:*		
2. A. Are you currently taking any medications (Over-the-Counter or Prescribed)? *If "YES", list:*		
B. Do you have any allergies to medicine? If "YES", list:		
3. Do you have any work restrictions or physical limitations?		
4. Do you require any work accommodations for the position which you are applying for, or presently performing? *If "YES", list:*		

I certify that I fully understand all requests 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:**

FOR MEDICAL USE ONLY	
I have reviewed the information provided: *(MD Signature)*	Date:

Medical Surveillance Enrollment:

- ☐ None
- ☐ Cleared
- ☐ Recommend this employee to be enrolled in the following programs
  - ☐ TB Program
  - ☐ BBP Program
  - ☐ Rabies Program
  - ☐ Allergy
  - ☐ Q Fever
  - ☐ Respiratory Protection
- ☐ Further Recommendations