

**UNIVERSITY OF PITTSBURGH  
HEALTH QUESTIONNAIRE**

**BSL – 3 WORKER HEALTH SCREENING**

<b>Name</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date</b>
<b>SS# or Pitt ID#</b>	<b>What is your position? (or position you are applying for?)</b>	
<b>Date of Birth</b>	Job/Position: _____	
<b>Address</b> _____	Department: _____	
<b>City/State/Zip Code</b> _____	Principle Investigator _____	
<b>Home Phone</b> (____) _____	Work Address _____	
	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 HISTORY**

GENERAL OCCUPATIONAL HISTORY					
1. What are your job duties?		2. Previous job title and number of years on job			
3. What were your duties?					
4. Do you work with, or have you been immunized against any of the following:	Work With	Immunized	Section 4 continued..	Work With	Immunized
Clostridium Botulinum			Rift Valley Virus		N/A
Vaccinia			Eastern Equine Encephalitis		N/A
Human Retroviruses		N/A	Monkey Pox		
Avian Flu		N/A	Yersinia Pestis (Plaque)		N/A
SARS			Brucella species		N/A
West Nile		N/A	Yellow Fever		
Francisella Tularemia		N/A	Japanese Encephalitis		
Bacillus Anthracis (Anthrax)			Toxoplasma Gondii		
Dengue		N/A	Chikungunya		N/A
Radio-isotopes		N/A	Malaria		
Chemotherapeutic agents		N/A	H2N2		
Burkholderia species		N/A	Other		

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MEDICAL HISTORY	YES	NO	MEDICAL HISTORY - (cont.)		
<b>Do you have, or have you ever had:</b> <i>(If YES to any of the following, please explain in the comment section)</i>			<b>COMMENTS:</b>		
1. Do you have any condition that weakens the immune system such as HIV/AIDS, leukemia, cancer, agammaglobulinemia?					
2. Do you have a severe autoimmune disease such as systemic lupus erythematosus that may significantly depress the immune system?					
3. Are you currently taking immunosuppressive drugs like oral steroids (e.g. Prednisone) drugs for autoimmune disease or drugs taken after an organ transplant?					
4. Are you currently taking cancer treatment with drugs or radiation?					
5. Do you have a chronic medical condition ,such as chronic renal failure, chronic liver disease, Diabetes, or chronic heart or lung disease?					
6. Have you had your spleen removed?					
7. Are you currently pregnant?					
8. Recent Foreign Travel					
9. Allergic rhinitis/conjunctivitis/hay fever					
10. Asthma					
11. Chronic cough					
12. Eczema/urticaria/hives					
13. Family history of allergic disease (please explain)					
14. Skin Diseases					
15. Seizure Disorders					
16. Other					

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*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:

Date:

(Medical Practitioner Signature)

- Normal Risk
- Elevated Risk

COMMENTS:

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