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**: MyHealth@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. **TEAMS Link** – [Pitt AESP Health Questionnaire 2022 (office.com)]

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: _______________________________

Pitt ID: 2P

Date of Birth: _______________________________ Job Position: _______________________________

Department - BSL1, BSL2, BSL3, DLAR, RBL

Home Address: _______________________________ Work Email: _______________________________

City/State/Zip: _______________________________ Supervisor/PI: _______________________________

Cell Phone: _______________________________

Occupational Review

What are your job duties?

________________________________________

Please indicate all species of animals that you will be working with or will be listed on a protocol for:

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>Yes</th>
<th>No</th>
<th>Check all that apply</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rodents</td>
<td></td>
<td></td>
<td>Macaques--Rhesus, Cynomolgus</td>
<td></td>
<td></td>
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<tr>
<td>Mice/Rats/Hamsters/ Gerbils/Guinea Pigs (Circle)</td>
<td></td>
<td></td>
<td>Baboons</td>
<td></td>
<td></td>
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<tr>
<td>Prairie Dogs</td>
<td></td>
<td></td>
<td>Farm Animals</td>
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<tr>
<td>Rabbits</td>
<td></td>
<td></td>
<td>Sheep/Goats/Swine (Circle)</td>
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<tr>
<td>Ferrets</td>
<td></td>
<td></td>
<td>Dogs</td>
<td></td>
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<tr>
<td>Fish/Frogs/Turtles (Circle)</td>
<td></td>
<td></td>
<td>Cats</td>
<td></td>
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<tr>
<td>Non-Human Primates</td>
<td></td>
<td></td>
<td>Tissue Handler: Human/Animal (Circle)</td>
<td></td>
<td></td>
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<tr>
<td>New world monkeys--squirrel monkeys</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
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</tbody>
</table>

I will not be working with animals or human/animal tissue, but this form is required for my lab’s protocol.

TB Review

Date of last TB Skin/QuantiFERON Test: Month:___________ Year:___________

Have you ever had a positive TB screening? Yes No

If YES: Were you treated with medication? Yes No

Date of last chest X-Ray (if prior positive TB test)? Month:____ Year:___________
**Infectious Disease Review**

Please indicate if you have a history of an immunization (I), have worked with in the past (P), or will work with (W) any of the following?

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>I</th>
<th>P</th>
<th>W</th>
<th>Check all that apply</th>
<th>I</th>
<th>P</th>
<th>W</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax</td>
<td></td>
<td></td>
<td></td>
<td>HIV</td>
<td></td>
<td></td>
<td>NA</td>
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<tr>
<td>Avian Flu</td>
<td>NA</td>
<td></td>
<td></td>
<td>Influenza Viruses</td>
<td></td>
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<tr>
<td>Botulinum</td>
<td></td>
<td></td>
<td></td>
<td>Human Retroviruses</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>Brucella</td>
<td>NA</td>
<td></td>
<td></td>
<td>Japanese Encephalitis</td>
<td></td>
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</tr>
<tr>
<td>Burkholderia Mallei</td>
<td>NA</td>
<td></td>
<td></td>
<td>Malaria</td>
<td></td>
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<td>NA</td>
</tr>
<tr>
<td>Burkholderia Pseudomallei (Meliodisis)</td>
<td>NA</td>
<td></td>
<td></td>
<td>Orthopox viruses (Monkey pox)</td>
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<tr>
<td>Chikungunya</td>
<td>NA</td>
<td></td>
<td></td>
<td>Rift Valley Fever Virus</td>
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<td></td>
<td>NA</td>
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<tr>
<td>Dengue</td>
<td>NA</td>
<td></td>
<td></td>
<td>SARS</td>
<td></td>
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<td>NA</td>
</tr>
<tr>
<td>Eastern Equine Encephalitis</td>
<td>NA</td>
<td></td>
<td></td>
<td>Toxoplasma Gondii</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>Francisella Tularemia</td>
<td>NA</td>
<td></td>
<td></td>
<td>Vaccinia</td>
<td></td>
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<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td>West Nile Virus</td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td>Yellow Fever Virus</td>
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<tr>
<td>Hepatitis C</td>
<td>NA</td>
<td></td>
<td></td>
<td>Yersinia Pestis (Plague)</td>
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<td>NA</td>
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<tr>
<td>Rabies</td>
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<td>Other:</td>
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</table>

**General Occupational Review**

What type of PPE have you used in the past?

________________________________________________________________________________________

Do you have prior history of working with animals?  

Yes  No

When?  Month/Year: to Month/Year:

If YES: Which species did you work with?

________________________________________________________________________________________
Medical History

Please list any history of any immunocompromised conditions (Lupus, Cancer, Organ Transplant, Oral Steroids, etc)

________________________________________________________________________

Please list any chronic health conditions (Diabetes, heart disease, cancer, liver disease, etc)

________________________________________________________________________

Please list any chronic skin conditions Eczema/Urticarial/Hives/Skin Disease

________________________________________________________________________

Please list any chronic Respiratory Diseases (Asthma, COPD, etc)

________________________________________________________________________

Please list any medications used to treat respiratory conditions

________________________________________________________________________

Do you now, or have you ever taken any asthma related medications?  Yes  No

If YES: Which medications and how often?

________________________________________________________________________

Do you have prior history of allergic symptoms with animal exposures? If so, to what animal(s)?  ____________________________

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
Please list any medications to control animal exposure/allergy symptoms:

________________________________________________________________________

________________________________________________________________________

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

Do you have or have you ever had a history to Anaphylaxis?  
Yes  No

If YES to Anaphylaxis, what was the cause?  
________________________________________________________________________

Have you ever had any allergy testing completed?  
Yes  No

If yes to having any allergy testing completed, when?  
________________________________________________________________________

If yes to having any allergy testing completed, what were the results?  
________________________________________________________________________

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?  
________________________________________________________________________

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

Have you ever been tested for a Latex Allergy?  
Yes  No

If YES to being tested for a Latex Allergy, what were the results?  
________________________________________________________________________
### General History

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have animals at home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES: Which kind of animal?</td>
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<tr>
<td>Have you traveled outside the US within the last year?</td>
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<tr>
<td>If YES: To which country/countries?</td>
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<tr>
<td>If YES: Have you had any health issues since returning?</td>
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<tr>
<td>Have you received a Tetanus Booster in the past 10 years?</td>
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<tr>
<td>When?</td>
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<tr>
<td>Do you have any other health problems?</td>
<td></td>
<td></td>
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<tr>
<td>If YES: Please list:</td>
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<td></td>
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<tr>
<td>Are you taking any other medications?</td>
<td></td>
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<tr>
<td>If YES: Please list:</td>
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</tbody>
</table>

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:** __________

MyHealth@Work STAFF ONLY

I have reviewed the information provided.

**Signature:** ____________________________ **Date:** __________