UNIVERSITY OF PITTSBURGH

BSL-3 WORKER HEALTH SCREENING QUESTIONNAIRE

This form can be faxed to: 412-647-5051 or filled out online at –

BSL - 3 Worker Health Screening (office.com)

Name		Date
Date of Birth	What is your current position? (or position you are applying for?) Job/Position: _____ Department: _____ Principle Investigator: _____ Work Address: _____ Work Phone: __(_____)_____	
Home Address: _____ Citi/State/Zip: _____ 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 were your previous job duties?	2. Previous job title and number of years on job:
3. What are your current job duties?	

4. Do you currently work with, have you ever worked with, or have you been immunized against any of the following:	Currently work with	Worked with in the past	Immunized	Section 4 continued…	Currently work with	Worked with in the past	Immunized
Bacillus anthracis				Dengue fever virus			N/A
Botulinum neurotoxin or toxin-producing species of Clostridium				Francisella tularensis			N/A
Eastern equine encephalitis virus				Highly pathogenic avian influenza virus			N/A
Japanese encephalitis virus				Human retroviruses			N/A
Monkey pox virus				Non-contemporary H2N2 (1957-1968) influenza virus			N/A
Mycobacterium tuberculosis				Plasmodium species			N/A
Vaccinia virus				Rift Valley fever virus			N/A
Yellow fever virus				SARS-associated coronavirus			
Brucella species			N/A	Toxoplasma gondii			N/A
Burkholderia mallei			N/A	Venezuelan equine encephalitis virus			N/A
Burkholderia pseudomallei			N/A	West Nile virus			N/A
Chikungunya fever virus			N/A	Yersinia pestis			N/A

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MEDICAL HISTORY			MEDCIAL HISTORY – (cont.)
Do you have, or have you ever had… (If yes to any of the following, please explain in the comment section)	YES	NO	COMMENTS:
1. Any condition that weakens the immune system such as HIV/AIDS, leukemia, cancer, agammaglobulinemia?			
2. 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 cancer treatment with drugs or radiation?			
5. Do you have a chronic medical condition such as chronic renal failure, chronic liver disease or chronic heart or lung disease?			
6. Have you had your spleen removed?			
7. Are you currently pregnant?			
8. Foreign travel within the last 12 months?			
9. Allergic rhinitis/conjunctivitis/hay fever?			
10. Asthma?			
11. Chronic cough?			
12. Eczema/urticarial/hives?			
13. Skin diseases?			
14. Seizure disorders?			
15. Diabetes mellitus?			
16. Do you currently take any medications?			If “YES” please list medications:

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Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and that you would like to confidentially discuss with the Occupational Health Practitioner?

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: (Medical Practitioner Signature)	Date:

□ Normal Risk
□ Elevated Risk

COMMENTS: