**OCCUPATIONAL HEALTH, MEDICAL SURVEILLANCE FORM**

The information requested in this questionnaire about your health status will be used only to detect disease or bodily dysfunction due to your work in the UM Laboratory Animal Resources facility before you would normally seek medical care. Your responses to this questionnaire are considered confidential; they will be reviewed by an occupational medicine physician, and stored in an off-campus medical office to ensure the security of your confidential information.

**INSTRUCTIONS:**

a) Fill in personal information below.

b) Send the questionnaire via campus mail or USPS to: Clinic Coordinator, Curry Health Center, 634 Eddy Street, UM, Missoula, MT 59812

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s date | GRIZ Card # | | Email Address | | | | |
| Name | | Date of Birth | | Age | Female  Male | |  |
|  |
| Mailing Address (UM or Home) | | City | | State | | Zip Code | |
| Job Title | | Work Phone | | | | | |
| PI/Supervisor | | UM Department | | | | | |

**Personal and Family Health Information**

1. Do you smoke cigarettes? Yes No

2. Are you taking any medications or immunosuppressive therapy such as prednisone, steroids, or anticancer drugs?

Yes  No

List any prescription medications you take.

List any nonprescription medications (over the counter) you take on a regular basis

3. If you are in contact with non-human primates:

Have you ever had Tuberculosis (TB)? Yes No

If yes, list medicines and how long you took them:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been vaccinated with BCG for TB? Yes No

Have you ever had a positive reaction to a TB test (Tine, PPD or Mantoux)? Yes No

If yes, list medicines and how long you took them:

4. Immunization and TB Screening History:

Vaccine/Test Date Completed

Tetanus, Most Recent Booster

Rabies, Initial Series

Rabies Booster, Most Recent

Rabies Immune Globulin

Hepatitis B Series

TB Screening (PPD)

Other:

**Laboratory Animal Use and Exposure Information**

Check the box below only if the statement is applicable to your future status:

|  |  |
| --- | --- |
|  | I will not be working with or around animals in the coming year. |
|  | I will only be involved in animal husbandry activities in the coming year. |
|  | I routinely wear a respirator while working in Laboratory Animal Resources. |

5. Current laboratory animal use:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Frequency of Exposure** | | | |
|  | **Animals/Tissues/Body Fluids** (check all that apply) | *Daily* | **1-4 times/week** | **1-3 times/month** | **Infrequent**  **(1-11 times/year)** |
|  | Rodents, rabbits, hamsters |  |  |  |  |
|  | Wild rodents |  |  |  |  |
|  | Birds |  |  |  |  |
|  | Reptiles |  |  |  |  |
|  | Fish |  |  |  |  |
|  | Other (specify): |  |  |  |  |

6. Current experimental agents you are exposed to in conjunction with laboratory animal studies:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | **Type of Agent** | **If yes, specify below:** |
|  | Yes |  | No | Infectious agents/r-DNA technologies |  |
|  | Yes |  | No | Chemical carcinogens |  |
|  | Yes |  | No | Non-carcinogenic organic chemicals |  |
|  | Yes |  | No | Non-carcinogenic inorganic chemicals |  |
|  | Yes |  | No | Heavy metals |  |
|  | Yes |  | No | Inhaled toxicants |  |
|  | Yes |  | No | Radiation |  |
|  | Yes |  | No | Anti-neoplastic agents |  |
|  | Yes |  | No | Known reproductive hazards/Teratogens |  |
|  | Yes |  | No | Other |  |

7. Have you ever had any of the following? (Please darken the appropriate box):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes |  | No | Animal allergies? Please list in space provided below. |
|  | Yes |  | No | Hay fever? |
|  | Yes |  | No | Allergic skin problems? |
|  | Yes |  | No | Asthma? |
|  | Yes |  | No | Chronic sinusitis? |
|  | Yes |  | No | Any other chronic respiratory disease? |
|  | Yes |  | No | Blood relatives with allergies to animals or asthma? Please describe in space provided below. |
|  | Yes |  | No | Medication allergies? Please list in space provided below. |
|  | Yes |  | No | Chemical or Metal allergies? Please list in space provided below. |
|  | Yes |  | No | Skin testing for allergies? Please describe in space provided below. |
|  | Yes |  | No | Autoimmune disorder (i.e., rheumatoid arthritis) requiring immune suppression medications? Please describe in space provided below. |
|  | Yes |  | No | Cancer/malignancy requiring chemotherapy? Please describe in space provided below. |
|  | | | | |

8. Have you regularly experienced any of the following symptoms in the last twelve (12) months?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Symptoms** | **No** | **Yes**  **(Month/Year of Onset)** | **Symptoms At Work?** | **Symptoms At Home?** |
| Watery, itchy eyes |  |  |  |  |
| Runny or stuffy nose |  |  |  |  |
| Sneezing spells |  |  |  |  |
| Cough |  |  |  |  |
| Wheezing/chest tightness/cough |  |  |  |  |
| Rash or hives |  |  |  |  |
| Shortness of breath |  |  |  |  |
| Difficulty swallowing |  |  |  |  |

9. Please note any other personal health history or current medical problems you consider significant in your work:

I certify that the above information is true and complete to the best of my knowledge.

Printed Name:  Date:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OCCUPATIONAL MEDICINE USE ONLY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Check (√) Normal (N)**  **Abnormal (A)**  **Not Observed (O)** | **N** | **A** | **O** | Height | Weight | BP | Pulse |
| Development |  |  |  | **COMMENTS:** | | | |
| Skin |  |  |  |
| Eyes |  |  |  |
| Ears |  |  |  |
| Nose and sinuses |  |  |  |
| Throat |  |  |  |
| Teeth and gums |  |  |  |
| Lymph glands |  |  |  |
| Chest |  |  |  |
| Lungs |  |  |  |
| Heart |  |  |  |
| Abdomen |  |  |  |
| Spine |  |  |  |
| Extremities |  |  |  |
| Neurological |  |  |  |

**RECOMMENDATIONS**

|  |  |
| --- | --- |
|  | Medically cleared to enter the Laboratory Animal Resources Facility and perform all required job functions without restrictions. |
|  | A medical condition was detected. The individual is medically cleared to enter the Laboratory Animal Resources Facility and perform all required job functions after correction or control of the condition or defect as noted. |
|  | A medical condition was detected. Medical clearance is reserved pending additional medical information. |
|  | A medical condition was detected. The individual is medically cleared to enter the Laboratory Animal Resources Facility and perform job functions within the limitations noted below. |
|  | The individual poses a Direct Threat to self or other employees. The individual is not medically cleared to enter the Laboratory Animal Resources Facility. |

Examiner Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**END**