

OMP Confidential Animal Handlers' Medical Surveillance Questionnaire

Complete Each Box	
Date Questionnaire Completed:	
Name:	
Date of Birth:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
IU Network ID/Email:	
Supervisor	
Department address:	
Department Phone:	
Home or Cell Phone:	
Animal Use/Exposure (check all that apply)	
<input type="checkbox"/> I am working on an approved animal use protocol and will be handling animals	
<input type="checkbox"/> I am not handling animals but will be working in areas where animals are housed	
<input type="checkbox"/> I will be working in animal biohazard areas	
<input type="checkbox"/> I am involved in veterinary care or animal husbandry	
<input type="checkbox"/> I am working with human specimens (cells, body fluids, etc.) in conjunction with animal studies	
<input type="checkbox"/> I handle animal as part of a research/teaching assignment	
<input type="checkbox"/> I work with animal carcasses, tissues, or specimens (non-fixed)	
Other (Specify)	

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Type of Animal Contact (All exposures in your Lifetime) (check all that apply)

Rodents:
(Mice, Rats, Hamsters, Guinea Pigs, Chinchillas)

Rabbits:

Cats:

Birds:
(i.e. Pigeons)

Reptiles:

Amphibians:

Fish:

Other (Specify)

Chemical Based Allergies (If so, explain)

Medication /Latex Allergies?

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A. History of Laboratory Animal Contact

1. In the first column below, enter the letter that corresponds to how frequently you are *currently* exposed to laboratory animals.

2. In the second column, enter the total length of time you have worked with each type of animal throughout your entire career.

Laboratory Animal Type	Frequency of <i>current</i> exposure a = never b = less than once a week c = 1 – 2 times a week d = 3 – 4 times a week e = daily	Total time worked with animals in your entire career.	
Mice	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Rats	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Hamsters	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Guinea Pigs	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Chinchillas	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Cats	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Rabbits	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Birds	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Reptiles	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Amphibians	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Fish	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Other (specify)	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months
Other (specify)	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/> years	<input style="width: 40px; height: 20px;" type="text"/> months

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B. Do you have any of the following symptoms that you feel are caused by, or made worse, because of any previous work with laboratory animals?

(Place check mark in box)	Yes	No
3. Watery, burning or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>
4. Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
5. Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
6. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
7. Cough	<input type="checkbox"/>	<input type="checkbox"/>
8. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>
10. Hives	<input type="checkbox"/>	<input type="checkbox"/>
11. Rash	<input type="checkbox"/>	<input type="checkbox"/>

C. Have you ever been told by a physician that you have:

(Place check mark in box)	Yes	No
12. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergic rhinitis (runny nose due to allergy)	<input type="checkbox"/>	<input type="checkbox"/>
14. Allergic conjunctivitis (itchy, watery eye from allergy)	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a history of?

(Place check mark in box)	Yes	No
15. Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
16. A natural parent or sibling with allergies to animals or their substances	<input type="checkbox"/>	<input type="checkbox"/>

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(Place check mark in box)	Yes	No
17. Have you ever had a positive allergy skin test performed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>

18. If yes, how many positive skin tests to non-animal antigens (such as grasses, pollen, house dust) have you had?
Check the appropriate number: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more <input type="checkbox"/>

19. If yes, how many positive tests to animal antigens (such as dog, cat, and mice) have you had?
Check the appropriate number: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more <input type="checkbox"/>

(Place check mark in box)	Yes	No
20. Do you smoke cigarettes (one or more per week)?	<input type="checkbox"/>	<input type="checkbox"/>

(Place check mark in box)	Yes	No
21. Will you need /wear a respirator as part of your study or work (Something other than a Surgical Mask (i.e.N-95))?	<input type="checkbox"/>	<input type="checkbox"/>

22. How many times have you been bitten/pecked that broke the skin by a laboratory animal?
Check the appropriate number: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more <input type="checkbox"/>

(Place check mark in box)	Yes	No
23. Have you ever <u>injured</u> yourself or become <u>ill</u> while as a result of working around laboratory animals or animal care facilities?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, place a check mark next to all injuries that apply:	
24. Animal bite/peck	<input type="checkbox"/>
25. Animal scratch	<input type="checkbox"/>
26. Muscle sprain or strain	<input type="checkbox"/>
27. Needle stick or scalpel injury	<input type="checkbox"/>
28. Laceration or cut on animal cage or equipment	<input type="checkbox"/>
29. Infection acquired from animal	<input type="checkbox"/>
30. Allergy to animal	<input type="checkbox"/>

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(Place check mark in box)	Yes	No
31. Do you have a history of heart valve disease or disorder (heart murmur), or congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>

If Yes,
What type of disease?

Date of diagnosis?

Treatment?

(Place check mark in box)	Yes	No
32. Do you have any impairment of your immune system?	<input type="checkbox"/>	<input type="checkbox"/>

If Yes,
What type of impairment?

Date of diagnosis?

Treatment?

(Place check mark in box)	Yes	No
33. Are you taking any immunosuppressive drugs, such as cortisone, prednisone, other steroids, or undergoing chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

What medication?

34. Date of last Tetanus immunization (year) :
(If you do not know when your last tetanus vaccination was, "unk")

35. If my health status changes I will report this to my supervisor for review.

36. Occupational Medicine Physicians may provide information to my employer about my ability to work, however the details of my medical history will be maintained at Occupational Medicine Physicians.

Employee Initial	<input type="text"/>	Sign Date	Mm/dd/yyyy
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