

Health Surveillance Questionnaire for Animal Contact and Use or Significant Biological Agents

Confidential Medical Information

CONFIDENTIALITY STATEMENT: This form requires that you provide personal health information that is protected by University policy and State and Federal law. Your rights to the confidentiality of your personal health information will be strictly maintained by Employee Health Services. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or business operations. You have the option of sending the form via regular mail or sending it via interoffice mail to the address above.

Full Name _____

Date of Birth _____

Animal / Biological Agent Contact

Please indicate the animals you work with (Check the box if you work with the specified animal).

Amphibians	<input type="checkbox"/>	Gerbils	<input type="checkbox"/>	Rats	<input type="checkbox"/>	Other (list):
Birds	<input type="checkbox"/>	Goats	<input type="checkbox"/>	Rabbits	<input type="checkbox"/>	
Cats	<input type="checkbox"/>	Guinea Pigs	<input type="checkbox"/>	Reptiles	<input type="checkbox"/>	
Cattle	<input type="checkbox"/>	Hamsters	<input type="checkbox"/>	Sheep	<input type="checkbox"/>	
Dogs	<input type="checkbox"/>	Mice	<input type="checkbox"/>	Swine	<input type="checkbox"/>	
Ferrets	<input type="checkbox"/>	Non-human Primates	<input type="checkbox"/>	Wild Rodents	<input type="checkbox"/>	
Fish	<input type="checkbox"/>	Poultry	<input type="checkbox"/>		<input type="checkbox"/>	

Please indicate tissue, blood, or biological agents that you work with (check the box if you work with the specified product).

Do you work with primate tissues? Yes No

Do you work in an area where primates or primate tissues are housed or handled? Yes No

Do you work with human blood products? Yes No

Do you work with animal blood products? Yes No

Do you work with human tissue? Yes No

Do you work with animal tissue? Yes No

Do you work with recombinant DNA technology? Yes No

If yes, does the research involve techniques in which viable, recombinant DNA-containing micro-

organisms are used to infect animals that then require Bio-safety level 3 containment? Yes No

Medical History

Have you had any changes in your health condition in the past year?

Do you have any breathing problems?

Do you have any heart problems?

Have you gained or lost 20 or more pounds in the past year?

Have you had any accidents or surgery to your jaw in the past year?

Have you been told by a physician that you have an immune compromising medical condition or are you taking medications that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)? Yes No

For Women: Are you pregnant, or planning to be pregnant in the next year? Yes No

Animal Allergies

Have you had any recent problems with the following symptoms? Yes No

Please indicate which symptoms you have experienced (check the yes or no box next to each symptom).

Condition	Yes	No	Condition	Yes	No
Watery or itching eyes			Shortness of breath		
Runny nose			Chest tightness		
Sneezing			Rash or hives		
Wheezing			Chronic allergies (dust, pollen, food, mold)		
Chronic cough			Asthma		

Are these more frequent while at work? Yes No

Are these symptoms associated with?

Dogs <input type="checkbox"/>	Cats <input type="checkbox"/>	Cattle <input type="checkbox"/>	Horses <input type="checkbox"/>	Bird (Feathers) <input type="checkbox"/>
Pigs <input type="checkbox"/>	Primates <input type="checkbox"/>	Rabbits <input type="checkbox"/>	Goats <input type="checkbox"/>	Sheep (Wool) <input type="checkbox"/>

Rats or Mice <input type="checkbox"/>	Guinea Pig <input type="checkbox"/>	Alfalfa <input type="checkbox"/>	Weeds <input type="checkbox"/>	Trees <input type="checkbox"/>
Chemicals <input type="checkbox"/>	Latex <input type="checkbox"/>	Wood <input type="checkbox"/>	Grasses <input type="checkbox"/>	Mold _____
Other <input type="checkbox"/> List: _____				

Have these required any treatment with over-the counter medications (Claritin, Benadryl, decongestants, eye drops, etc?) Yes No

Have you had to wear a respirator, goggles or protective clothing to protect yourself from allergies (e.g., hay fever [rhinitis], eye symptoms, hives or asthma) at work? Yes No

Have you been treated by your own physician for allergies that began at work? Yes No

Has your health status changed in the last year? No. Yes, please explain: _____.

If you suspect you may have work related allergies or have any other questions about your health status or this form, please contact UT Employee Health.

I decline to be enrolled in the Occupational Health Program at this time. I understand that I may enroll at any time in the future by calling Employee Health at 713-500-3261.

Signature _____