An occupational health program is necessary to ensure a safe and healthy workplace for personnel who work with animals in a research and educational setting. Specialty Health Clinic has been contracted to provide occupational medical services for all UNR personnel who work with animals. This questionnaire surveys your medical history and will help the reviewing clinician to assess your risk with respect to your medical health and potential issues from working with animals. This questionnaire represents a component of the occupational health and safety program for persons who work with animals within our IACUC-approved animal care and use program, as mandated by Public Health Service (PHS) Policy and AAALAC Accreditation Standards.

UNR employees who intend to work with animals must complete this medical questionnaire and be cleared by Specialty Health prior to working with animals. The completed questionnaire is maintained at Specialty Health; UNR does not maintain copies. Employees who are found to have risk factors that require further medical evaluation will be contacted directly by Specialty Health to schedule an appointment. An employee's supervisor may be contacted if repeated attempts to contact the employee regarding this questionnaire are unsuccessful.

**Submission Instructions:**
Your employer must allow you to answer this questionnaire during normal working hours or at a time and place that is convenient to you. To maintain confidentiality, your employer must not look at, or review your answers, and your employer will deliver the questionnaire in a sealed envelope to Specialty Health.

Fill out the form completely to the best of your ability, including name and personal information on all forms, except darkened sections indicated for Specialty Health use only. If you have questions or do not understand any part of the form, please contact Specialty Health as listed below for clarification of the instructions. Only licensed health care professionals at Specialty Health Medical Clinic will have access to your medical information; your employer and colleagues will not have access to your information.

**Specialty Health**
775-398-3630
330 E. Liberty, Suite 100
Reno, NV 89501

Place the completed questionnaire inside a sealed envelope. Write the words, “CONFIDENTIAL – OCC HEALTH FORM along with your name” across the seal and forward it to the IACUC Office at the address listed below so that your participation in this program for animal use access can proceed. If you are declining participation in this part of our program, please note below and sign page 6.

**IACUC Office,**
University of Nevada, Reno
1664 N. Virginia St. /MS 340
Reno, NV 89557- 8955

When Specialty Health receives your questionnaire, a licensed health care professional will review your information and provide occupational health recommendations to you in writing. As a part of this review, the health care professional may also contact you via telephone or ask you to come in for further evaluation on your behalf within the objectives of our animal use safety program.
# Medical Health Questionnaire

## Contact Information

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Date ________________________</td>
<td></td>
</tr>
<tr>
<td>2. Employee Name _____________________________________________________</td>
<td>3. NSHE No.________________</td>
</tr>
<tr>
<td>4. Gender □ Male □ Female</td>
<td>5. Date of Birth _____________________________</td>
</tr>
<tr>
<td>7. Your Height _______ ft. _______ in.</td>
<td>8. Your Weight __________ lbs.</td>
</tr>
<tr>
<td>11. Campus Address ____________________________________________</td>
<td>11. Department __________________</td>
</tr>
<tr>
<td>14. Employee Email ___________________________________________</td>
<td></td>
</tr>
<tr>
<td>15. Supervisor Name __________________________</td>
<td>16. Supervisor Phone ____________________________</td>
</tr>
<tr>
<td>17. Supervisor Email __________________________________________</td>
<td></td>
</tr>
<tr>
<td>18. If healthcare provider needs to contact you, what is the best time to call and preferred phone? __________________</td>
<td></td>
</tr>
<tr>
<td>19. □ Yes □ No  Has your employer told you how to contact the health care professional who will review this questionnaire?</td>
<td></td>
</tr>
<tr>
<td>20. □ Yes □ No  Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?</td>
<td></td>
</tr>
</tbody>
</table>

☐ I am declining participation in the health questionnaire component of the animal care and use occupational health program at this time. Check this box if you are declining, then sign the form on Page 6.

*Please note that you may elect to participate in this important part of our safety-oriented program at no cost to you at any time! Contact the IACUC Office (Tel. 682-6571) to re-join this program if you previously declined.*
**Medical Background Questions**

**ANY AREAS WITH AN ASTERISK REQUIRE PHYSICIAN EVALUATION**

**Section 1. Animal & Infectious Agent Contact (check all that apply to you)**

1. I have previously worked with animals (if checked, then please give details of species and work):

2. I will be working in the Vivarium with the following species:

3. I am working with human tissue specimens (cells, tissue, body fluids, blood, etc.) in conjunction with animal studies (if checked, please specify):

4. I work with the following infectious agents:

5. I have contact with animal tissues/fluids not treated with chemical preservatives (please specify):

6. I am not handling animals, but will be working in areas where animals are housed or used.

7. I am exposed to animals away from work (if checked, please specify which animals):

8. I had a confirmed illness from working with animals. If yes, please explain type/nature and date:
   - Type/nature: Date:
   - Type/nature: Date:
   - Type/nature: Date:

9. I think I have an injury or illness from working with animals (please explain):

**Section 2. Allergies (please check all that apply to you)**

10. Do you now have or have you ever had any of the following:
   - Yes □ No □ Asthma
   - Yes □ No □ If you have asthma, are your asthma symptoms aggravated when you are in contact with animals?
   - Yes □ No □ Have you experienced shortness of breath coughing, and/or wheezing while working with or around animals?
☐ Yes ☐ No Have you experienced itchy or watery eyes and/or runny or stuffy nose while working with or around animals?

☐ Yes ☐ No Do you have an allergy to any animals or animal byproducts and/or molds?
   If yes, please explain______________________________________________________________

☐ Yes ☐ No Does anyone in your family have an allergy to any animals or animal byproducts and/or mold?
   If yes, please explain:____________________________________________________________

☐ Yes ☐ No Do you have season allergies/hay fever?

☐ Yes ☐ No Is there a family history of allergies?

☐ Yes ☐ No Do you have/get skin rashes from working with animals, gloves, or chemicals?
   If yes, please explain:____________________________________________________________

☐ Yes ☐ No Have you ever had an asthmatic/anaphylactic reaction to anything?
   If yes, please explain type/nature and date.
   Type/nature:_________________________________________ Date:_____________________
   Type/nature:_________________________________________ Date:_____________________
   Type/nature:_________________________________________ Date:_____________________

Section 3. Immunization and Tuberculosis Test History

Vaccinations

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Dose/Test</th>
<th>Date (mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tetanus</td>
<td>Last Dose</td>
<td></td>
</tr>
<tr>
<td>2. Hepatitis B</td>
<td>1st Dose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2nd Dose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3rd Dose</td>
<td></td>
</tr>
<tr>
<td>3. Tuberculin skin test (PPD) or IGRA blood test</td>
<td>Last Test</td>
<td></td>
</tr>
</tbody>
</table>

Comments regarding immunization/TB history:__________________________________________________________________________

Section 4. Precautions (please check all that apply to you)

1. Do you wear a respirator?  ☐ Yes ☐ No

2. If you wear a respirator, have you had it “Fit” tested?  ☐ Yes ☐ No

3. Have you filled out a respirator screening or questionnaire?  ☐ Yes ☐ No
4. When working with animals, how often do you wear the following?
   a. Gloves          □ Never □ Rarely □ Sometimes □ Always
   b. Gown or Coveralls □ Never □ Rarely □ Sometimes □ Always
   c. Surgical Mask    □ Never □ Rarely □ Sometimes □ Always
   d. Disposable Respirator □ Never □ Rarely □ Sometimes □ Always
   e. Non-Disposable Respirator □ Never □ Rarely □ Sometimes □ Always
   f. Protective Eyewear □ Never □ Rarely □ Sometimes □ Always
   g. Face Shield      □ Never □ Rarely □ Sometimes □ Always
   h. Hearing Protection □ Never □ Rarely □ Sometimes □ Always

5. How frequently do you do the following after handling animals at work?
   a. Wash Hands       □ Never □ Rarely □ Sometimes □ Always
   b. Change Clothes   □ Never □ Rarely □ Sometimes □ Always
   c. Shower           □ Never □ Rarely □ Sometimes □ Always

6. Do you work in or around heavy equipment or machinery? □ Yes □ No

7. Do you work in areas with high noise levels? □ Yes □ No

8. Do you work with high temperature water or steam? □ Yes □ No

9. Do you work in an area with wet floors or standing water? □ Yes □ No

10. Do you work in an area that requires heavy lifting? □ Yes □ No

Section 5. Medical History (please check all that apply to you)

1. Do you have a chronic medical condition that requires medication? □ Yes □ No
   a. If “yes” to the above answer, please provide an explanation below.

2. Have you been told by your physician that you have an immune compromising medical condition? □ Yes □ No
   a. If “yes” to the above answer, please provide an explanation below.

3. Are you pregnant or planning on becoming pregnant? □ Yes □ No

4. Are you taking medications that impair your immune system? □ Yes □ No
   (e.g., steroids, immunosuppressive drugs, or chemotherapy)?
   a. If “yes” to the above answer, please provide an explanation below.
5. Do you have or has your physician told you that you have a valvular or congenital heart condition?  □ Yes  □ No

6. So you have a history of problems with your spleen or absence of a spleen?  □ Yes  □ No

7. Are you aware of any current health problems not listed above that affect your work with animals?  □ Yes  □ No
   If yes, please explain. ________________________________________________________________
   ____________________________________________________________

15. Would you like to talk with the health care professional that reviews your questionnaire about any concerns you have regarding your health and working with animals?  □ Yes  □ No

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**General Consent for Review and Release of Medical Information**

I certify that the above statements are true, complete, and correct to the best of my knowledge.

I give consent to Specialty Health to review this information on behalf of the University of Nevada, Reno. I understand that this review is undertaken for my safety in the job environment and understand that I may be further contacted by Specialty Health either for clarifications or further evaluation. Further evaluation may include, but is not limited to, a physical examination, blood tests, an evaluation of lung function, and other diagnostic tests as necessary. Costs for personal evaluation are covered in the Occupational Health contract between Specialty Health and the laboratory and are not the responsibility of the individual or the University.

I further understand that the results of this evaluation and any subsequent tests or treatments that relate to my job and the performance of essential job functions may be released to my supervisor and the IACUC Responsible Official.

Employee Signature ________________________________________________________________

Printed Employee Name __________________________________________ Date ________________

OR

I understand that if I decline participation in the Occupational Health Program, my employment status might change to meet acceptable safety standards.

Employee Signature ________________________________________________________________

Printed Employee Name __________________________________________ Date ________________
This page is to be kept in the patient file at Specialty Health.

Please check all that apply:

☐ Employee does not request or require further evaluation and is released to work with animals based on medical history presented in the questionnaire. (Please sign Medical Clearance Statement on the following page.)

☐ Medical exam by a licensed Health Care Provider recommended.

☐ Medical exam by a licensed Health Care Provider required.

☐ Medical exam by a licensed Health Care Provider requested by the Employee.

☐ Cleared for respirator use. Will forward Respirator Medical Evaluation Form to Crista Hartman at EH&S (MS 328) for respirator fit test.

☐ Recommended immunization (circle all that apply): tetanus (or ppd), flu shot, Anthrax, other

__________________________________________________________

Signature of Reviewer

__________________________________________________________

Printed Name of Reviewer Date
Employee Name__________________________________ Review/Exam Date ___________________________

As they pertain to working with animals, the following are the results of the medical examination and/or reviewing the medical history of the above employee:

☐ The employee is cleared to work with animals without restrictions.

☐ The employee is cleared to work with animals with the following restrictions or alterations to standard operating procedures:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

☐ The employee is NOT currently cleared to work with animals and a follow up medical evaluation is required.

☐ The employee is DENIED clearance to work with animals.

Signature of Health Care Professional ____________________________________________________

EMPLOYEE MAY NOT BEGIN WORK WITH ANIMALS UNTIL:

- All medical surveillance requirements are completed and the healthcare professional has approved medical clearance to work with animals.
- All signatures are present on this form.