

ANIMAL EXPOSURE SURVEILLANCE QUESTIONNAIRE

Confidential - for Occupational Health Services Use Only

Instructions:

This Questionnaire will be utilized by Occupational Health Services to assess your risk of working with laboratory animals. The information you provide will be held in the strictest confidence and not shared with anyone outside of Occupational Health Services. Please complete it to the best of your ability. If you are unsure, or are uncomfortable answering any of the questions, please leave them blank. Fax the completed Questionnaire to Ellen Bibb, RN at 410 955-1617

GENERAL INFORMATION

Name: _____ Today's Date: _____ / _____ / _____

Last 4 Digits of Social Security#: _____ Badge ID: _____ JHED ID: _____

Date of Birth _____ / _____ / _____ Sex: Male Female

Answer these questions about the job you are applying for or the job where you are currently working:

PI: _____ Department: _____

Departmental Address: Building: _____ Room: _____

Work Telephone Number: _____ E-mail Address: _____

Job Title: _____ Date the job starts: _____ / _____ / _____

Status: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Faculty | <input type="checkbox"/> Academic Staff | <input type="checkbox"/> Post-Doc Fellow |
| <input type="checkbox"/> Undergraduate Student | <input type="checkbox"/> Graduate Student | <input type="checkbox"/> Civil Service Staff |
| <input type="checkbox"/> Employee | <input type="checkbox"/> Other _____ | |

Occupation: (Check one)

- | | | |
|--|---|--|
| <input type="checkbox"/> Graduate Student | <input type="checkbox"/> Animal Care Worker/Handler | <input type="checkbox"/> Lab Technician |
| <input type="checkbox"/> Research/Teaching Personnel | <input type="checkbox"/> Veterinarian | <input type="checkbox"/> Veterinarian Technician |
| <input type="checkbox"/> Other _____ | | |

OCCUPATIONAL ANIMAL EXPOSURE HISTORY

- Have you ever worked with laboratory animals? Yes No
- How many months you have worked with laboratory animals? _____ (months)
- Check the boxes below if you have been in contact with the following animals. Please specify contact hours/day, total duration (months), and months.

ANIMAL	Previously	Currently	Never	Contact Hours/Day	Total Months	Months At JH
Rats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Rabbits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Guinea Pigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Old World Monkeys (Baboon, Macaque, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
New World Monkeys (Squirrel, Marmoset, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cattle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hamsters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Gerbils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prairie Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sheep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Goats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Swine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

If other, please specify: _____

4. Do you think that you are allergic to any of these animals? Yes No
 If yes, please check all that apply:
 Rats Mice Rabbits Guinea Pigs Monkeys Cattle
 Dogs Cats Hamsters Gerbils Prairie Dogs Dogs
 Sheep Goats Swine Other (specify) _____
5. Do you use or wear any of the following items when working with animals?
 Protective Eye Glasses Yes Sometimes No
 Mask/Respirator Yes Sometimes No
 Lab Coat Yes Sometimes No
 Gloves Yes Sometimes No
6. Have you ever contracted a disease from animals, or experienced an animal related injury (including bites, scratches, needle sticks, etc.)? Yes No
 If yes, please explain: _____
7. Are you involved with recombinant DNA technology or microorganisms that contain recombinant DNA? Yes No Unknown
 If yes, does the research involve techniques in which viable, recombinant DNA-containing microorganisms are used to infect animals that require Bio-safety level 2 or 3 containment? Yes No Unknown
 Explain: _____
8. Are any agents of the following hazardous groups used in these animals?
 Infectious Teratogenic/Carcinogenic Radioactive Other: _____
 Please list if checked: _____

HOME ENVIRONMENT INFORMATION

9. Do you have any indoor pets? Yes No
 If yes, which animals and for how long?
- | Animal | 1-2 Years | 2-3 Years | 3-4 Years | Over 4 Years |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Dogs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cats | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (Type): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
10. Please List Your Hobbies: _____
11. Do you smoke cigarettes? Yes No
12. Do you think you may have non-pet mice or other animals in your home? Yes No

MEDICAL HISTORY

13. Do you regularly have any of the following symptoms? Yes No
 If yes, please indicate the symptom and frequency of onset. Also check in what location or time period the symptom (s) is/are present:

Symptom	ONSET		FREQUENCY				SYMPTOMS PRESENT			
	Year Started	Weekly	Monthly	Yearly	Rarely	At Work	At Home	On Vacation	No Difference	
Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Tightness	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colds	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty in Swallowing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hay Fever	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hives	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Itchy Eyes	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nose Congestion	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Runny Nose	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

breath	_____								
Sinus Problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sputum	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Production	_____								
Swelling of Eyes	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
or Lips	_____								
Wheezing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Were you ever told by a doctor that you had allergies? Yes No

15. Have you ever been skin tested for allergies? Yes No

If yes, what substances were you found to be allergic to or sensitized to?

- Ragweed Grass Trees Mold Mice
 Dust Cat Dog Other: _____

16. Have you ever received allergy (desensitization/immunotherapy) shots? Yes No

If yes, what year did you receive the shots? _____

17. Has a doctor ever said you have asthma? Yes No

If yes, what year did your asthma start? _____

Are you currently taking medication (either over the counter or by prescription) to control your asthma? Yes No

If yes, what medications are you on? _____

18. Has a doctor ever told you that you have a medical condition caused by your working conditions?

Yes No

If yes, what is the condition? _____

19. Have you ever been treated for the following diseases?

Yes No

If yes, please check the illnesses:

- | | | |
|--|---|--|
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Recurrent Bronchitis | |

20. List prescribed and over the counter medications:

Name of Medication	Reason for taking	Last time taken

21. Have you ever had an occupational illness or injury? Yes No

If yes, when? _____

What happened? _____

22. Did this injury or illness cause:

- permanent change of position temporary assignment termination of a job

23. Did you ever receive workers' compensation? Yes No

IMMUNIZATIONS

24. Check the box and indicate date(s) of most recent vaccination or blood tests to document antibody status. Please approximate the date if you can't remember the exact date.

Measles	<input type="checkbox"/>	_____	Mumps	<input type="checkbox"/>	_____	Rubella	<input type="checkbox"/>	_____
Hepatitis A	<input type="checkbox"/>	_____	Hepatitis B	<input type="checkbox"/>	_____	CMV	<input type="checkbox"/>	_____
Toxoplasmosis	<input type="checkbox"/>	_____	'Q' Fever	<input type="checkbox"/>	_____	BCG	<input type="checkbox"/>	_____
Rabies	<input type="checkbox"/>	_____	Vaccinia (smallpox)	<input type="checkbox"/>	_____	Varicella (chickenpox)	<input type="checkbox"/>	_____

Date of last rabies booster: _____ Date of last tetanus booster: _____
If not immunized for chickenpox, did you have chickenpox? Yes No

TUBERCULOSIS SCREENING

25. Date of last PPD skin test: _____ / _____ / _____ Positive Negative

If Positive, date of last chest x-ray: _____ / _____ / _____

If Positive, in past, are you having any of the following symptoms?

Weight loss Shortness of breath Chronic cough Bloody sputum Fever

FOR WOMEN ONLY

26. Are you pregnant? Yes No

27. Are you planning to be pregnant in the next year? Yes No

Comments: _____

Reviewed By: _____

Date: _____ / _____ / _____