

Occupational Health and Safety Program Laboratory Animal Resources

Binghamton University
State University of New York
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Annual Health Screening Questionnaire for Faculty, Staff, and Students currently enrolled in the OH&S-LAR Program

****Confidential Medical Information****

(This information is strictly for the use of the Occupational Health and Safety Program for Laboratory Animal Resources and may not be released to anyone without your written consent.)

****Please return this form enclosed in an envelope marked confidential to:
Dr. Diane L. Paukett, D.O. at OH&S-LAR****

Section 1: Personal Information – Please Print

Contact Information

Last Name _____ First _____ Middle _____
Home Address _____ City _____ State _____ Zip _____
Campus Address _____
Campus Phone _____ Local phone or Cell phone # _____
Email _____ Birth Date _____ Sex: M F

In Case of an Emergency

Person to be notified _____ Relationship _____ Phone _____
Name of Primary Care Physician _____ Phone _____

University Department Information

Department _____ Investigator's Lab working in _____

Date of anticipated completion of undergraduate or graduate studies _____

Section 2: Risk Assessment

1. Employment Status

Animal Handler/Technician Undergraduate Student Graduate Student
 Faculty Other (list job description)

2. Please check all the animal species which you are working with at present

Rat Mouse Reptile Bird Rabbit Other (list) _____

3. Please check the box below which approximates the time you plan to spend:

Working in an animal lab and/or Doing field work

Daily (List number of hours/day if changed from last yr.) _____ Weekly Monthly
 Rarely (Less than once a month)
 Not handling animals but working in the Animal Laboratory environment (please explain) _____

Section 3: Medical History Screening

Have you been told within the last year that you have any of the following conditions? (Please check all that apply)

1. Asthma (If yes)
 - a. **Is your Asthma under control with your present treatment?** Yes No
 - b. **Are your Asthma symptoms triggered by any of the following?** (Check all that apply) Allergies
 Fumes Cold Heat Other (Please describe) _____
2. Allergies
 - a. **If there is a history of new Allergies please check all that apply:**
 Mold Dust Foods (List) _____ Medications (List) _____
 Pollens Animals (List) _____
 - b. **Any new symptoms from existing Allergies?** Yes No
(If yes, please explain) _____
 - c. **Any new allergy to Latex or another type of gloves?** Yes No
 - d. **Within the past year have you had an anaphylactic reaction?** Yes No
3. Heart disease (If yes, please explain) _____
4. **Any changes in your immune status within the past year?** Yes No
 - a. If yes, please explain _____
 - b. Are you currently on immunosuppressive medication? Yes No
5. **Are you presently being treated for any acute or chronic illness?** Yes No
If yes, please explain: _____
6. **(For females only) are you pregnant?** Yes No
7. **Have you received the following immunizations within the past year?** (If so, please list date of most recent vaccinations or boosters) Tetanus _____ Hepatitis B _____
8. **Do you presently have any work restrictions?** Yes No
(If yes, please explain): _____
9. **Have you developed any of the following symptoms within the last year?** (Check all that apply)
 Chronic cough Wheezing Night-time cough
 Itchy or irritated eyes Hives Skin rash
10. **Do you have any new symptoms that have developed over the last year which you feel may be related to your work environment?** Yes No
(If yes, please explain) _____

I attest that the information above is correct to the best of my knowledge.

I understand and give my permission for this information to be entered in a Confidential, centralized database for purposes of reducing risk of exposure to relevant vaccine preventable diseases, allergens, zoonotic diseases, and bloodborne pathogens.

Signature _____

Date _____