

Animal Exposure Questionnaire

University of Minnesota
Occupational Health Clinic
Boynton Health Service
410 Church St SE
Minneapolis, MN 55455
612-626-9423

For Office Use Only:

MD Review Required: yes no

Date Completed: _____

Action:

OK Restrict Appt: _____

Date Review Completed: _____

PURPOSE

The purpose of this form is to obtain information about your personal health and work exposures. This information will be used by the Occupational Health Professional (OHP) to make an accurate assessment of your ability to safely work with animals/agents at the University. The OHP will document for you and your supervisor any work restrictions or protective measures to be followed (*see privacy statement*). If restrictions and/or protective measures are required, it is the University's expectation that you will comply.

The University of Minnesota Office of Occupational Health and Safety has contracted with the Occupational Health Clinic (OHC) at Boynton Health Service (BHS) to provide these services.

PRIVACY STATEMENT

The following information requested on the form is private: date of birth, sex, home address (unless listed in the campus directory) and all items under *Medical History*. If you decline to answer any questions, you must complete the *Waiver* at the end of this form.

The OHC at BHS will maintain health and treatment information about you in a confidential medical record to ensure your privacy. The OHC at BHS will not release confidential information about you without your written consent, except as required by law. The OHC at BHS will however notify your supervisor and the Office of Occupational Health and Safety of work restrictions or protective measures to be followed and whether you have completed all occupational health requirements applicable to you.

DIRECTIONS

Please fill out the enclosed questionnaire. BE SURE TO PRINT CLEARLY. Return the form in a *sealed* envelope to: Occupational Health Clinic, Boynton Health Service, 410 Church St. S.E., Minneapolis, MN 55455, campus mail code: MMC188, or forms can be transmitted to a *confidential* fax in a *secured* location at **612-624-3310**. If you are faxing this form, write your last name, employee ID, or x.500 at the top of each page. If you have questions regarding this form, please call 612-626-9423. The OHC may contact you via phone or email for any further information.

PARTICIPANT INFORMATION

Date: _____ Email Address: _____ U of M Employee ID#: _____

Name: *Last* _____ *First* _____ *Middle* _____

Sex: _____ Date of Birth: ____ mm ____ dd _____ yyyy

Job Title: _____ Department: _____

Principal Investigator/ Supervisor: _____

Home Mailing Address:

Street: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Campus Mailing Address:

Street: _____ City: _____

State: _____ Zip: _____ Work Phone: _____

For office use only:

ROHP: _____ DB/B: _____ Respirator: _____ Resp Received: _____ HepB _____ F/U Date: _____

CONTACT WITH ANIMALS/BIOLOGICAL AGENTS

1. With what specific animals will you be working? Check all that apply.

- Rabbits Bats Mice Rats Guinea Pigs Other Rodents
 Dogs Cats Sheep Pigs Farm Animals Aquatic Life
 Non-human primates (macaque)
 Non-human primates (other)
 Other (Please list) _____

2. Total numbers of hours/week that you will have animal contact in your job:

- Less than 3 hours/week 3-10 hrs/week 11-24 hrs/week
 25 hrs or more/week
 Occasional/Irregular/Non-scheduled (i.e. maintenance, inspections)
 Please explain the nature of your anticipated contact

3. Please describe, in your own words, the type and extent of animal contact you will have:
(For example: Regular direct care of animals including feeding and cleaning)

4. If you will be working with any of the following you must check either the "Yes" or "No" box for all conditions below:

- | | |
|---|--|
| a. Unfixed animal tissues.
If yes, please list type of animal tissue is from | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | |
| b. Live viruses (such as rabies, vaccinia)
If yes, please list type of live virus: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | |
| c. Animals infected with coxiella burnetti (Q fever) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Blood borne pathogens (Hepatitis B, HIV, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Human blood, body fluid or unfixed tissue | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Mycobacterium | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Avian influenza | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Hazardous chemicals, including anesthetics
If yes, please list chemicals: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | |
| h. Other infectious agents not listed above
If yes, please list: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | |
| i. Radioactive materials
If yes, please list radioactive material: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <hr/> | |

MEDICAL HISTORY

5. Have you ever had any problems working around animals? Yes No
If yes, please describe problem and when it occurred:

5a. Do you currently have any problems working around animals? Yes No

6. Do you have any known allergies (not just to animals)? Yes No
If so what are you allergic to?

7. Have you ever had allergy testing (skin testing or blood lab work) Yes No
If yes, please list allergens you had positive test for:

8. Do you have any of the following types of reactions *around animals*? Please check “Yes” or “No” to indicate if you are currently experiencing the reaction (Current Reaction) or experienced it more than 12 months ago (Past Reaction).

Reactions	Current Reaction		Past Reaction	
Runny/stuff nose	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Itching eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest tightness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Throat swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anaphylaxis (inability to breathe/swallow)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

What makes these reactions **worse**?

What makes these reactions **better**?

If you have **other reactions**, please describe:

MEDICAL HISTORY (CONTINUED)

9. Are you allergic to latex? Yes No
If yes, please describe reaction:

- 9a. Do you have any current symptoms associated with latex? Yes No
If yes, please describe your symptoms

10. Do you wear a respirator at work at the University of Minnesota? Yes No
****Note: A surgical mask is not considered a respirator and you do not need to complete the Respirator Medical Evaluation.****

If NO, please continue with question 11 on page 6.

If YES, please complete the following questions (a-h).

- a) Have you completed a Respirator Medical Evaluation form at the University of Minnesota and submitted it to the Occupational Health Clinic at Boynton Health Service? Yes No

If YES, please continue with question b.

If NO, you must download, print, and complete the Respirator Medical Evaluation at the following link. http://www.bhs.umn.edu/occhealth/Respirator_Med_Eval.pdf Submit it with your Animal Exposure Questionnaire and continue with question b.

(If you have been medically cleared to wear a respirator by another healthcare professional please submit your clearance form with your Animal Exposure Questionnaire. For questions contact the Occupational Health Clinic at ohbhs@umn.edu or 612-626-9423)

- b) Is your use of a respirator required or voluntary? required voluntary

- c) What type of respirator do you wear? (check all that apply)

- Surgical Mask (pictured below) Filtering Facepiece (Dust mask/N-95) (both pictures below)
Note: This is not a respirator!



(Respirators Continued on Next Page)

MEDICAL HISTORY (CONTINUED)

Full-Face Respirator (pictured below)



Half-Face Respirator (pictured below)



Powered Air Purifying Respirator (PAPR) (pictured below)



Other : _____

d) Do you wear a respirator to prevent allergy symptoms? Yes No
If yes, please describe your symptoms

e) Do you wear a respirator to prevent other physical symptoms? Yes No
If yes, please describe your symptoms

f) Do you wear a respirator to prevent exposure to a particular pathogen or infectious agent? Yes No
If yes, please list agent

MEDICAL HISTORY (CONTINUED)

g) Do you wear a respirator to prevent exposure to a particular chemical? Yes No
If yes, please list chemical

h) Do you wear a respirator for other reasons? Yes No
If yes, please list reason:

11. Are you currently on any work restrictions or activity limitations? Yes No
If yes, please describe:

12. Do you have any concerns or questions about occupational health and safety issues related to your job? Yes No
If yes, please describe below:

Note: Certain medical conditions, such as immunosuppression and pregnancy, increase your risk of potential health problems working with animals. Questions 13-15 ask about such conditions.

13. Do you have any diseases that suppress your immune system (such as lupus, cancer, etc.) Yes No
If yes, please list:

MEDICAL HISTORY (CONTINUED)

14. Do you currently take any medications that may suppress your immune system? Yes No
(For example prednisone, steroids or chemotherapy)
If yes, list medications:

15. Do you have any other health conditions that you think could be adversely affected by your work? Yes No

If yes, please list the condition(s)

16. For Females:
Are you pregnant or do you anticipate becoming pregnant in the next 12 months? Yes No

SIGNATURE OF PARTICIPANT

The above information is accurate and complete to the best of my knowledge

Signature _____ **Date**
The University of Minnesota Office of Occupational Health and Safety encourages employees to contact the Occupational Health Clinic at Boynton Health Service (612) 626-9423 with any questions about how their health might be affected by exposure to workplace hazards.

QUESTIONNAIRE WAIVER

I choose not to complete this questionnaire or have declined to answer specific questions. I understand that, without all of the requested information, the health care professional who reviews my responses will not be able to conduct a full individualized assessment of my occupational health risks or provide a medical certification for my position working with animals/agents. I understand that this may result in increased health risks to me. I also understand that I might not qualify to receive or continue in certain job positions unless I fully complete the questionnaire.

I understand the University encourages me to contact Boynton Health Service at (612) 626-9423 or my own health care provider if I have any questions about how my health might be affected by exposure to animals/agents.

Signature _____ **Date**