

# MSUM Occupational Health and Safety Program

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## HEALTH ASSESSMENT FOR PERSONS INVOLVED IN ANIMAL PROJECTS

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_

Local Address \_\_\_\_\_

Permanent Address \_\_\_\_\_

Local Phone \_\_\_\_\_ Permanent Phone \_\_\_\_\_

MSUM Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_ Species of Animal to be handled: \_\_\_\_\_

### If you wish to “Decline to Participate”, please sign now.

I, \_\_\_\_\_, on \_\_\_\_\_ (Date), decline to participate in the Occupational Health Assessment and medical evaluation, treatment and surveillance program. (If opting out of this questionnaire, this form is to be **returned to your supervisor for retention**)

### If you wish to participate, please continue with this questionnaire.

If you answer “yes” to any of the questions in this category, it is recommended that you submit this questionnaire to a medical provider for review since work with animals may involve an increased risk for you. *These answers are confidential and should be discussed directly with a healthcare provider.*

\_\_\_\_\_ A. Is animal husbandry an essential part of your duties (provide food/water, clean cages, groom animals, etc.)? ***Essential means it is the reason the duty/responsibility of the job exists.***

- No animal Contact
- No direct contact, but enters animal facility
- Does not conduct procedures on live animals, but handles “unfixed” tissues and fluids.
- Handles, restrains, collection of specimens or administers substances to live animals.
- Performs invasive procedures such as surgery, necropsy.

\_\_\_\_\_ B. Do you work with (or in the proximity of) pregnant mammals?

\_\_\_\_\_ C. Do you work with (or in the proximity of) wild-caught mammals and/or wild-caught birds?

\_\_\_\_\_ D. Do you work with (or in the proximity of) venomous animals?

\_\_\_\_\_ E. Does your work with animals require you to be in contact with agents that are infectious to humans (blood or other tissues from animals infected or contaminated with a pathogen)? List the agent(s) \_\_\_\_\_

\_\_\_\_\_ F. Do you have known or suspected allergies to animals?

\_\_\_\_\_ G. Do you have chronic health problems (diabetes, asthma, high blood pressure, etc.)?

\_\_\_\_\_ H. Do you have renal or liver disease?

\_\_\_\_\_ I. Do you have heart disease?

- \_\_\_\_\_ J. Do you have immune system deficiencies (or other medical conditions that may limit your ability to carry out your duties)?
- \_\_\_\_\_ K. Do you have pre-existing allergic tendencies (hay fever, eczema, cholinergic urticaria, etc.)?
- \_\_\_\_\_ L. Do you have a history of spleen problems or have you had a splenectomy (spleen removal)?
- \_\_\_\_\_ M. Are you pregnant?
- \_\_\_\_\_ N. Are you under current therapy using high dose steroids, radiation, or carcinogens?
- \_\_\_\_\_ O. Do you work directly with the rabies virus or have direct contact with animals quarantined for rabies surveillance?
- \_\_\_\_\_ P. Are you exposed to animals or animal parts with potential of containing infectious rabies virus and/or are you responsible for the control of wild animals on campus?

Will the work involve any of the following?

- |                                      |        |
|--------------------------------------|--------|
| 1. Biological Agents                 |        |
| a. Recombinant DNA                   | Yes No |
| b. Infectious Agents                 | Yes No |
| 2. Human Blood, Tissues, or Cells    | Yes No |
| 3. Physical Agents                   |        |
| a. Caustic, flammables or cryoagents | Yes No |
| b. Noise                             | Yes No |
| c. Radiation                         | Yes No |
| d. Radioisotopes                     | Yes No |
| e. Extreme environmental conditions  | Yes No |
| f. Lasers                            | Yes No |
| 4. Chemical Agents                   |        |
| a. Anesthetic gases                  | Yes No |
| b. Drugs/Chemotherapeutic agents     | Yes No |
| c. Heavy Metals                      | Yes No |

**Personal Health History:** Please answer all questions and comment on “yes” answers in space provided. Have you had? (Check all that apply)

- |                                 |                                     |
|---------------------------------|-------------------------------------|
| 1. Asthma _                     | 22. Heart Disease _                 |
| 2. Serious Allergies _          | 23. Chest pain/pressure _           |
| 3. Bronchitis _                 | 24. Shortness of breath/emphysema _ |
| 4. Chicken pox _                | 25. Rapid/Irregular heartbeat _     |
| 5. Tuberculosis (or exposure) _ | 26. High blood pressure _           |
| 6. Diabetes _                   | 27. Low blood pressure _            |
| 7. Thyroid disorder _           | 28. Back problems/pain _            |
| 8. Kidney disorder _            | 29. Benign tumors _                 |
| 9. Urinary problems _           | 30. Cancer _                        |
| 10. Recurrent headaches _       | 31. Jaundice _                      |
| 11. Head injury _               | 32. Epilepsy/seizure disorders _    |
| 12. Loss of consciousness _     | 33. Toxoplasmosis _                 |
| 13. Recent weight gain _        | 34. Digestive problems _            |
| 14. Recent weight loss _        | 35. Insomnia _                      |
| 15. Prolonged anxiety _         | 36. Gall bladder disorder _         |
| 16. Vision problems _           | <i>(Women)</i>                      |
| 17. Hearing problems _          | 37. Irregular period's _            |
| 18. Carpal Tunnel Syndrome _    | 38. Severe cramps _                 |
| 19. Musculo-skeletal problems _ | 39. Excessive flow _                |
| 20. Neurological problems _     | 40. Pregnancy _                     |
| 21. Hepatitis A, B, or C _      | 41. Miscarriage _                   |

**Comments: (regarding “yes” answers above)**

Has your physical activity been restricted during the past five years? \_\_\_\_\_ Describe: \_\_\_\_\_

Have you had any surgery during the past five years? \_\_\_\_\_ Describe: \_\_\_\_\_

Have you been seriously ill or injured during the last five years? \_\_\_\_\_ Describe: \_\_\_\_\_

Are you currently receiving medical treatment/counseling \_\_\_\_\_ Describe: \_\_\_\_\_

Do you take any medications routinely? \_\_\_\_\_ Describe: \_\_\_\_\_

DO YOU HAVE ALLERGIES TO CHEMICALS? \_\_\_\_\_ Name: \_\_\_\_\_

DO YOU HAVE ENVIRONMENTAL ALLERGIES? \_\_\_\_\_ Name: \_\_\_\_\_

DO YOU HAVE MEDICATION ALLERGIES? \_\_\_\_\_ Name of drug(s): \_\_\_\_\_

**RECORD OF VACCINATIONS RECEIVED:**

Date of last Tetanus booster: \_\_\_\_\_

**PROVIDERS NOTES AND RECOMMENDATIONS:**

- No medical evaluation/vaccine recommend based on the information provided.
- Recommended evaluation/vaccine recommend based on submitted information.
- Notified individual of recommended medical evaluation/vaccine.

Health Care Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Return this health assessment survey to your supervisor**