University of Pittsburgh Animal Exposure Surveillance Program (AESP)
Health Questionnaire 2014

Instructions for Enrollment

1. To initiate enrollment, call Dr. Yolanda Lang of Employee Health Services at 412-647-3407.
2. Complete this Animal Exposure Surveillance Program Health Questionnaire.
3. Email the completed Questionnaire to Dr. Lang at langyc@upmc.edu or Fax to Dr. Lang at 412-647-5051, or bring it to the clinic at the time of the assessment in Employee Health.
4. Do NOT send the completed form via campus mail.
5. Do NOT send the completed form to your supervisor.
6. Do NOT send the completed form to the Department of Environmental Health and Safety.
7. Enrollment in the Animal Exposure Surveillance Program is completed at the Employee Health Services Clinic, 3708 Fifth Avenue, Medical Arts Building, Suite 500.59, Pittsburgh, PA 15213 between 7:30 a.m. and 3:00 p.m. Monday through Friday.

All information collected by this University of Pittsburgh program will be handled with the strictest confidence and in compliance with all applicable regulations. Your personal and medical information will only be available to those clinical care providers in Employee Health Services with a need to know.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employer and other entities covered by GINA Title II from requesting genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individuals’ family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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Demographics

Name:		**Date:**	
SSN:		**Pitt ID:**	**2P**
Date of Birth:		**Job Position:**	
Gender (circle one):	Male Female	**Department:**	
Home Address:		**Work Email:**	
City/State/Zip:		**Work Phone:**	
Home Phone:		**Supervisor/PI:**	

Occupational Review

What are your job duties? ____________________

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

Please indicate all species of animals that you may be working with on your current job:

Rodents	Yes	No	Macaques--Rhesus, Cynomolgus	Yes	No
Mice/Rats/Hamsters/ Gerbils/Guinea Pigs	Yes	No	Baboons	Yes	No
Prairie Dogs	Yes	No	Farm Animals	Yes	No
Rabbits	Yes	No	Sheep/Goats/Swine	Yes	No
Ferrets	Yes	No	Dogs	Yes	No
Fish/Frogs/Turtles	Yes	No	Cats	Yes	No
Non-Human Primates	Yes	No	Other:		
New world monkeys--squirrel monkeys	Yes	No			

TB

Have you ever had a TB Skin Test? Yes No

If YES: Date of last TB Skin Test: Month: Year:

Have you ever had a reaction to the TB Skin Test? Yes No

If YES: Were you treated with medication? Yes No

Date of last chest X-Ray: Month: Year:

Have you or anyone in your family ever had TB/Tuberculosis? Yes No

Do you have any of the following symptoms:

Unexplained fever or chills Yes No

Unexplained weight loss or night sweats Yes No

Productive cough or blood tinged sputum Yes No

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Infectious Disease Review

Do you work with, or have you been immunized against any of the following:

Anthrax	Yes	No	HIV	Yes	No
Avian Flu	Yes	No	H1N1	Yes	No
Botulinum	Yes	No	Human Retroviruses	Yes	No
Brucella	Yes	No	Japanese Encephalitis	Yes	No
Burkholderia Mallei	Yes	No	Malaria	Yes	No
Burkholderia Pseudomallei (Meliodisis)	Yes	No	Monkey Pox	Yes	No
Chikungunya	Yes	No	Rift Valley Fever Virus	Yes	No
Dengue	Yes	No	SARS	Yes	No
Eastern Equine Encephalitis	Yes	No	Toxoplasma Gondi	Yes	No
Francisella Tularemia	Yes	No	Vaccinia	Yes	No
Hepatitis A	Yes	No	West Nile Virus	Yes	No
Hepatitis B	Yes	No	Yellow Fever Virus	Yes	No
Hepatitis C	Yes	No	Yersinia Pestis (Plague)	Yes	No

General Occupational Review

Have you ever used protective clothing or equipment at work? Yes No

Ear/Hearing Protection	Yes	No	Other:
Eye Protection	Yes	No	
Respirators	Yes	No	
Type:			

Have you ever had exposure to the following at work:

Anesthetic Gases	Yes	No	Lasers	Yes	No
Blood Borne Pathogen	Yes	No	Radio-Isotopes/ Radiation Exposures	Yes	No
Chemotherapeutic Agents	Yes	No			

Do you have prior history of working with animals: Yes No

If YES: How long did you work with animals? ______________________

When? Month/Year: ____________ to Month/Year: ____________

If YES: Which species did you work with? ______________________

If YES: What type of work environment? ______________________

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Medical History

Do you now, or have you ever had:

Agammaglobulinemia — Yes No

Anaphylaxis — Yes No

Asthma — Yes No

If YES: When? ____________________

If YES: What triggered the asthma? ____________________

Cancer — Yes No

Diabetes — Yes No

If YES: Date of diagnosis? ____________________

If YES: Do you take any medications? — Yes No

If YES: Which medications and how often? ____________________

____

Eczema/Urticarial/Hives/Skin Disease — Yes No

If YES: Where was/is the skin irritation located? ____________________

____

If YES: What medication/cream is used and how often? ____________________

____

Hay Fever — Yes No

If YES: What medication/cream is used and how often? ____________________

____

Leukemia — Yes No

Do you now, or have you ever taken any asthma related medications? — Yes No

If YES: Which medications and how often? ____________________

____

Allergy History

Do you have prior history of allergic symptoms with animal exposures? — Yes No

If YES: Which of the following symptoms have you experienced:

- Chest tightness or wheezing — Yes No
- Coughing — Yes No
- Itching/Tearing/Swelling of Eyes — Yes No
- Nasal Discharge/Stuffiness — Yes No
- Sneezing — Yes No

If YES: Have you used any medications to control allergy symptoms? — Yes No

If YES: Which medications and how often? ____________________

____

If YES: Was the medication effective in controlling your symptoms? — Yes No

If YES: Have you used any protective equipment (mask, gloves, etc.) to control allergy exposure/symptoms? — Yes No

If YES: Was the protective equipment effective in controlling your symptoms? — Yes No

Allergy History (continued)		
Have you ever had any allergy testing completed?	Yes	No
If YES: When?		
If YES: Was it positive?	Yes	No
If POSITIVE: What was it positive for?		
Have you ever taken any allergy injections?	Yes	No
If YES: When, and were they effective?		
Have you ever had a severe reaction to latex devices or products?	Yes	No
If YES: Under what circumstances did it occur?		
Have you ever been told by a doctor that you have an allergy to latex?	Yes	No
If YES: To what product did the doctor say you were allergic?		
After handling latex products, have you ever experienced any of the following:		
Difficulty breathing	Yes	No
Chapped or "cracking" of hands	Yes	No
Itching, redness and/or swelling (hands, eyes)	Yes	No
Hives	Yes	No

General History		
Do you now or have you ever had animals at home?	Yes	No
If YES: Which kind of animal?		
If YES: Did you have any reaction to them?	Yes	No
If REACTION: What symptoms?		
If REACTION: Do you take any medications related to the reaction?	Yes	No
Have you traveled outside the US within the last year?	Yes	No
If YES: To which country?		
If YES: Have you had any health issues since returning?	Yes	No
Have you received a Tetanus Booster in the past 10 years?	Yes	No
Have you ever received a Rabies Vaccination?	Yes	No

General History (continued)

Do you have any other health problems? Yes No

If YES: Please list:

Are you taking any other medications? Yes No

If YES: Please list:

I certify that I fully understand all request for information contained on this form and I certify that the information supplied by me on this form is complete and correct to the best of my knowledge.

Signature: ____________________ **Date:** ____________________

EMPLOYEE HEALTH STAFF ONLY

I have reviewed the information provided.

Signature: ____________________ **Date:** ____________________