BSL – 3 WORKER HEALTH SCREENING QUESTIONNAIRE

Name	Gender ☐ Male ☐ Female	Date
Pitt ID#	What is your current position? (or position you are applying for?)	
Date of Birth	Job/Position: _____	
Home Address _____	Department: _____	
City/State/Zip Code _____	Principle Investigator _____	
Home Phone _____(_____)_____	Work Address _____	
	Work Phone: __(_____)_____	
	Date of Birth _____	

NOTE: If you do not know the answer to a question, or do not wish to answer any particular questions, please discuss those questions with the staff at the time of the evaluation.

OCCUPATIONAL HISTORY

GENERAL OCCUPATIONAL HISTORY					
1. What were your previous job duties?			2. Previous job title and number of years on job		
3. What are your current job duties?					
4. Do you currently work with, have you ever worked with, or have you been immunized against any of the following:	Work With	Immunized	Section 4 continued..	Work With	Immunized
Bacillus anthracis			Dengue fever virus		N/A
Botulinum neurotoxin or toxin-producing species of ***Clostridium***			***Francisella tularensis***		N/A
Eastern equine encephalitis virus			Highly pathogenic avian influenza virus		N/A
Japanese encephalitis virus			Human Retroviruses		N/A
Monkeypox virus			Non-contemporary H2N2 (1957-1968) influenza virus		N/A
Mycobacterium tuberculosis			***Plasmodium*** species		N/A
Vaccinia virus			Rift Valley fever virus		N/A
Yellow fever virus			SARS-associated coronavirus		N/A
Brucella species		N/A	***Toxoplasma gondii***		N/A
Burkholderia mallei		N/A	Venezuelan equine encephalitis virus		N/A
Burkholderia pseudomallei		N/A	West Nile virus		N/A
Chikungunya fever virus		N/A	***Yersinia pestis***		N/A

MEDICAL HISTORY	YES	NO	MEDICAL HISTORY - (cont.)		
Do you have, or have you ever had: ***(If YES to any of the following, please explain in the comment section)***			**COMMENTS:**		
1. Do you have any condition that weakens the immune system such as HIV/AIDS, leukemia, cancer, agammaglobulinemia?					
2. Do you have a severe autoimmune disease such as systemic lupus erythematosus that may significantly depress the immune system?					
3. Are you currently taking immunosuppressive drugs like oral steroids (e.g. Prednisone), drugs for autoimmune disease or drugs taken after an organ transplant?					
4. Are you currently taking cancer treatment with drugs or radiation?					
5. Do you have a chronic medical condition ,such as chronic renal failure, chronic liver disease, or chronic heart or lung disease?					
6. Have you had your spleen removed?					
7. Are you currently pregnant?					
8. Foreign Travel within last 12 months?					
9. Allergic rhinitis/conjunctivitis/hay fever					
10. Asthma					
11. Chronic cough					
12. Eczema/urticaria/hives					
13. Family history of allergic disease (please explain)					
14. Skin Diseases					
15. Seizure Disorders					
16. Diabetes Mellitus					
17. Claustrophobia (fear of closed spaces)					
18. Do you currently take any medications?			**If "YES" please list medications:**		

Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and that you would like to confidentially discuss with the Occupational Health Practitioner?

I certify that I fully understand all requests 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*:***

FOR MEDICAL USE ONLY	
I have reviewed the information provided: ***(Medical Practitioner Signature)***	**Date:**

☐ **Normal Risk**

☐ **Elevated Risk**

COMMENTS: