***Initial Health Surveillance Questionnaire***

Return completed form to Occupation Health RN at mail code 2104

|  |  |  |  |
| --- | --- | --- | --- |
| Name (Last, First, MI) | ASU ID | | ASURITE |
| Home Address | Home Phone | | Date of Birth |
| Work Phone | | Today's Date |
| Job Title | E-mail | | |
| Supervisor | Department | Mail Code: | |
|
| Area/Org Number to Charge: ECR A402 | | | |

**PART A: Occupational / Environmental Risk Factors**

**1. Laboratory Animal Use**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Animals/Tissues/Body Fluids Used or Handled** | | **Frequency of Contact** | | | |
| *Check all that apply* | | *Daily* | *1-3 times*  *per week* | *1-3 times*  *per month* | *Infrequent (0-6 times per year)* |
|  | Rodents, rabbits, dogs, cats |  |  |  |  |
|  | Marine mammals, amphibians, reptiles, marine and fresh |  |  |  |  |
|  | Wild rodents, wild birds |  |  |  |  |
|  | Cattle, swine, poultry |  |  |  |  |
|  | Sheep, goats |  |  |  |  |
|  | Nonhuman primates, monkeys |  |  |  |  |
|  | Other (specify): |  |  |  |  |

**2. Risk Assessment for Laboratory Animal Use**

Are you exposed to any of the following in conjunction with animal studies?

|  |  |  |  |
| --- | --- | --- | --- |
| *Yes* | *No* |  | *If yes, specify:* |
|  |  | A. Infectious Agents |  |
|  |  | B. Recombinant/synthetic DNA Technologies |  |
|  |  | C. Chemical Carcinogens |  |
|  |  | D. Radiation |  |
|  |  | E. Anti-Neoplastic Agents |  |
|  |  | F. Known Reproductive Hazards/Teratogens |  |
|  |  | G. Human Specimens (cells, bodily fluids, etc.) |  |
|  |  | H. Other |  |

**PART B: Personal Health History**

**1. Infectious Disease and Immunization History**

All individuals must have a Tetanus vaccination within the last 10 years.

For individuals who are working with **NHPs**: Two measles, mumps, and rubella (MMR) vaccinations in lifetime, or a current positive measles titer, is required.

Please complete the following table and attach verifying documentation from your physician’s office:

If you were born before 12/31/56, you do not need to provide proof of MMR vaccinations, but must provide proof of tetanus vaccination received within the last 10 years.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Immunizations** | | | **Disease** | |
|  | *Yes* | *Year(s)* | *No* | *Yes* | *Year(s)* |
| Tetanus (DTP or Td) |  |  |  |  | |
| MMR #1 (series of two required; measles, mumps, rubella) |  |  |  |  |  |
| MMR #2 (second vaccination) |  |  |  |  |  |

**2. Environmental Allergies / Asthma**

|  |  |  |  |
| --- | --- | --- | --- |
| *Yes* | *No* | *Don’t Know* | *Do you exhibit any of the following symptoms (runny nose; itchy, watery eyes; rashes; shortness of breath or difficulty breathing) when exposed to:* |
|  |  |  | Animals? |
|  |  |  | If yes, which animals? |
|  |  |  | Environmental allergens (pollen, mold, dust)? |
|  |  |  | Chemicals? |
|  |  |  | If yes, which chemicals? |
|  |  |  | List the treatment you receive to relieve your allergies. |
|  |  |  | Do you have asthma? |
|  |  |  | Do you have any skin problems related to work (e.g., reactions to latex gloves)? |
|  |  |  | If yes, describe. |
|  |  |  |  |

**3. Additional Information for High Risk Employees / Students (those using primates, sheep, or goats)**

**Nonhuman Primate Users ONLY**

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* |  |
|  |  | 1. Have you had naturally-acquired measles (Rubeola)? |
|  |  | 1. Have you had TWO MMR vaccinations in your life time (provide evidence) |
|  |  | 3. Tuberculosis Surveillance |
|  |  | a. Have you ever lived in countries other than the United States? |
|  |  | If yes, list countries. |
|  |  | b. Have you had active tuberculosis? |
|  |  | If yes, list year and describe treatment. Proceed to item h. |
|  |  | If no: |
|  |  | c. Date of last tuberculosis (TB) skin test: |
|  |  | d. Result of TB skin test:  Positive  Negative |
|  |  | e. Have you received the tuberculosis vaccine Bacillus Calmotte Guerin (BCG)? If no, proceed to item h. |
|  |  | f. If you have received BCG, have you had a tuberculin skin test since the vaccination? If no, proceed to item h. |
|  |  | g. If you have had a tuberculin skin test since a BCG vaccination, what were the results?  Positive  Negative |
|  |  | h. Date of last chest x-ray:       Reason x-ray was taken: |

**Sheep and/or Goat Users ONLY**

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* |  |
|  |  | 1. Do you have a history of known valvular disease (heart murmurs) or congenital heart disease? |
|  |  | If yes, date of diagnosis: |
|  |  | Type of disease: |
|  |  | Treatment: |
|  |  | 2. Do you now have or have you had Q-fever? |

**4. Additional Personal Health Concerns – all animal users**

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* |  |
|  |  | Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and would like to confidentially discuss with ASU Health Service or your personal care physician? |

I have answered the questions on this form truthfully and to the best of my recollection.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission to ASU Health Services (including any health care professional appointed by ASU Health Service and directly involved in my care) and the ASU Institutional Animal Care and Use Committee (IACUC) to exchange medical information concerning me when necessary to coordinate my medical care. I understand this exchange is for the purpose of coordinating a safe work environment and to assure compliance with policies as adopted by the IACUC.

This release does not entitle other offices or departments of Arizona State University including, but not limited to, academic departments, or the ASU Police to obtain information about me, unless those offices are otherwise entitled to the information or unless I specifically approve the release of such information in writing. I may revoke this release at any time in writing, but I understand that revocation will not affect any release made prior to the revocation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date