SAINT LOUIS UNIVERSITY

Occupational Health Program for Laboratory and Animal Research

Medical History Questionnaire

The Medical Component of the Occupational Health Program (OHP) centers around three things:

1. Medical History Evaluation
    a. The purpose of the OHP Medical History Questionnaire (MQ) is to obtain information about personal health as it relates to potential work exposure to biological pathogens, recombinant DNA, and/or laboratory animals.
    b. The MQ should be completed by each participant. Personnel should follow the instructions on page two of this document. The completed medical questionnaire is reviewed by Employee Health with attention to animal allergies, ergonomics, and immune suppression issues.
    c. Personnel may decline the medical services portion of the program by filling out the declination form (last page) in addition to the MQ. In order to decline medical service BOTH the MQ and the declination form must be signed and returned to Employee Health.

        Please Note: Declining the medical services of the Occupational Health Program may prevent a worker from participating in certain research that is part of their job or project. Workers should discuss declination with supervisor prior to completing the form.

    d. Instructions for returning documentation to Employee Health are listed on page two.

2. Tetanus immunization every 10 years
    a. Employee Health will advise each participant if an update is needed.

3. Evaluation of work related injuries and illnesses
    a. Should a work-related injury or illness occur related to work in laboratory and/or animal research facilities, the involved employee must report it immediately to their supervisor, and an Employee Report of Injury Form must be completed.
    b. The supervisor should phone ahead to advise either Employee Health or SLU Hospital Emergency Room of the incident and incoming exposed patient.
    c. The injured employee should be referred to:
        Employee Health
        SLU Hospital West Pavilion (enter off Rutger Street)
        Hours: 7:30 am to 4:00 pm Monday-Friday (excluding holidays)
    d. If the work related injury or illness occurs outside business hours or if the work related injury is severe, the injured employee should report to the Emergency Room at SLU Hospital.
        i. If the initial treatment occurs in the ER, the injured employee MUST follow up with Employee Health on the next working day. An original Employee Report of Injury Form must be provided to Employee Health at the time of evaluation.

Saint Louis University
Occupational Health Program for Laboratory and Animal Research

MEDICAL HISTORY QUESTIONNAIRE

INSTRUCTIONS

You are being asked to complete this questionnaire to obtain information about your personal health as it relates to potential work exposure to biological pathogens, recombinant DNA, and/or laboratory animals. Various regulatory and oversight agencies require that all research institutions (including SLU) have such an occupational health program. This questionnaire may be completed at the time of hire, if you start working on a new protocol, or at intervals while working on an existing protocol.

- **The information you provide in this form will become part of your Employee Health record.** This information will NOT become part of your SLU personnel record, a SLUCare medical record, or a hospital medical record.
- After completing the questionnaire, please submit it to Employee Health (EH). To ensure confidentiality, it is best to use the EH secure, confidential fax line: 314-268-5537. You can keep the original for your own records after you check the fax confirmation from your machine. Alternatively, the form can be interoffice mailed to EH. If mailed, it is recommended that you keep a copy for your own records.
    - Employee Health (Confidential)
    - 3655 Vista Avenue, West Pavilion Suite 116

- After reviewing your responses, Employee Health may contact you to discuss the need for further medical evaluation. If you would like further medical evaluation at any time related to potential work exposures, contact Employee Health.
- Even if you decline medical services, complete the Medical History sections prior to signing the medical services declination form and returning it to Employee Health.
- For any questions about the Occupational Health Program, contact:

    Employee Health at 314-268-5499

♦♦♦ Employee Health ♦♦♦

REGISTRATION INFORMATION

NAME _____ Date: _____

☐Tenet ☐University ☐Other _____

OCCUPATION: _____

DEPARTMENT _____ SHIFT _____

SUPERVISOR _____ SUPERVISOR PHONE _____

SOCIAL SECURITY NUMBER (last four digits) XXX--XX-- _____ _____ _____ _____

BIRTHDATE _____ -- _____ -- _____ AGE _____ SEX ☐FEMALE ☐MALE

MARITAL STATUS ☐single ☐married Religious preference (optional) _____

HOME ADDRESS _____

_____ ZIP_____

HOME PHONE _____ WORK PHONE _____

PAGER # _____ CELL # _____

EMAIL _____

BIRTH COUNTRY _____ # OF YEARS IN THE U.S. _____

CURRENT MEDICATIONS _____

_____

_____

ALLERGIES _____

♦♦♦ Employee Health ♦♦♦

providing work related healthcare services for employees of Saint Louis University and Saint Louis University Hospital-Tenet Healthcare

3655 Vista Avenue, West Pavilion Suite 116
St. Louis, MO 63110-2539
phone – 314-268-5499
fax – 314-268-5537

FORM VERSION 3 (23 JAN 2012)

♦♦♦ Employee Health ♦♦♦

MEDICAL HISTORY--Please mark YES for medical conditions that you have now or have had in the past. For *each* YES marked item, please write explanation in the space provided provided. Mark NO for all others.

YES	NO	
☐	☐	chicken pox in _____ (year)
☐	☐	fatigue
☐	☐	allergic reactions
☐	☐	rashes
☐	☐	skin diseases/dermatitis
☐	☐	scars
☐	☐	identifying marks
☐	☐	hives/chronic itching
☐	☐	glove powder reaction
☐	☐	watery eyes
☐	☐	nasal congestion
☐	☐	wheezing
☐	☐	reactions to animals
☐	☐	latex reaction
☐	☐	head injury/skull fracture
☐	☐	frequent headaches
☐	☐	memory trouble
☐	☐	epilepsy/convulsions/fits
☐	☐	mental trouble
☐	☐	concussion
☐	☐	fainting/lightheadedness
☐	☐	dizzy/balance problem
☐	☐	loss of consciousness
☐	☐	stroke
☐	☐	paralysis
☐	☐	thinking trouble
☐	☐	sleep disorder
☐	☐	glasses
☐	☐	contacts
☐	☐	blindness
☐	☐	color blindness
☐	☐	glaucoma
☐	☐	cataracts
☐	☐	eye trouble
☐	☐	decreased hearing
☐	☐	draining ear
☐	☐	ringing in the ears
☐	☐	ruptured ear drum
☐	☐	hearing aid
☐	☐	hay fever/allergies
☐	☐	frequent sore throats
☐	☐	sinus trouble
☐	☐	tonsillectomy

YES	NO	
☐	☐	tuberculosis
☐	☐	history of positive PPD
☐	☐	BCG vaccination
☐	☐	INH therapy in the past
☐	☐	chronic cough
☐	☐	coughing up blood
☐	☐	unexplained weight loss
☐	☐	night sweats
☐	☐	fever
☐	☐	chest pain
☐	☐	current smoker
		____ packs per day for _____years
☐	☐	previous smoker
		quit in _____ (year)
☐	☐	pneumonia
☐	☐	asthma/wheezing
☐	☐	emphysema
☐	☐	chronic bronchitis
☐	☐	shortness of breath
☐	☐	worn a respirator
☐	☐	collapsed lung
☐	☐	chest discomfort
☐	☐	heart trouble
☐	☐	heart attack/artery block
☐	☐	palpitations
☐	☐	heart valve trouble
☐	☐	high blood pressure
☐	☐	low blood pressure
☐	☐	carotid disease
☐	☐	ulcer-indigestion
☐	☐	stomach trouble
☐	☐	gall bladder disease
☐	☐	appendicitis
☐	☐	liver disease/jaundice
☐	☐	hepatitis A
☐	☐	hepatitis B
☐	☐	hepatitis C
☐	☐	diabetes/frequent boils
☐	☐	pancreas disease
☐	☐	thyroid disease
☐	☐	weight gain
☐	☐	weight loss
☐	☐	blood in stools

YES	NO	
☐	☐	kidney trouble/stones
☐	☐	hemorrhoids/piles
☐	☐	constipation
☐	☐	hernia/rupture
☐	☐	blood/infection of urine
☐	☐	back pain
☐	☐	back injury
☐	☐	back surgery
☐	☐	lumbar strain
☐	☐	swollen joints
☐	☐	arthritis
☐	☐	hand/wrist trauma
☐	☐	hand/wrist fracture
☐	☐	swelling legs/ankles
☐	☐	varicose veins/leg ulcer
☐	☐	gout
☐	☐	deformity
☐	☐	amputation
☐	☐	rheumatism
☐	☐	stiff joints
☐	☐	broken bones/fractures
☐	☐	cancer
☐	☐	operations/surgery
☐	☐	hospitalizations
☐	☐	tumor
☐	☐	anemia/bleeding/bruises
☐	☐	blood disease/leukemia
☐	☐	fear of heights
☐	☐	fear of small places
☐	☐	drink alcohol beverages
		how much? _____
☐	☐	recreational drug use
☐	☐	prior military service
☐	☐	rejected for military
☐	☐	rejected for life insurance
☐	☐	second job
☐	☐	medically rejected for employment
for females only		
☐	☐	gynecological surgery
for males only		
☐	☐	prostate disease

☐ ☐ Do you have any abnormal or decreased sensation, numbness, tingling in the fingers/hands/wrists/forearms?

☐ ☐ Are you presently under the care of a physician?

(Print Name)

List any hobbies: _____

WRITE ANY EXPLAINING REMARKS HERE:

(Print Name)

Laboratory Animal Exposure History

1. _____ **Animal Protocol number(s) for this OHP enrollment**
2. ☐Yes ☐No **Have you ever worked with laboratory animals?**
3. _____ (months) **How many months you have worked with laboratory animals?**
4. **Check the boxes below if you have been in contact with animals and specify contact hours/day, total duration, months at SLU.**

ANIMAL	Previously	Currently	Never	Contact Hours/Day	Total Months	Months At SLU
Rats	☐	☐	☐	_____	_____	_____
Mice	☐	☐	☐	_____	_____	_____
Rabbits	☐	☐	☐	_____	_____	_____
Guinea Pigs	☐	☐	☐	_____	_____	_____
Old World Monkeys (Baboon, Macaque, etc.)	☐	☐	☐	_____	_____	_____
New World Monkeys (Squirrel, Marmoset, etc.)	☐	☐	☐	_____	_____	_____
Cattle	☐	☐	☐	_____	_____	_____
Dogs	☐	☐	☐	_____	_____	_____
Hamsters	☐	☐	☐	_____	_____	_____
Gerbils	☐	☐	☐	_____	_____	_____
Prairie Dogs	☐	☐	☐	_____	_____	_____
Sheep	☐	☐	☐	_____	_____	_____
Goats	☐	☐	☐	_____	_____	_____
Swine	☐	☐	☐	_____	_____	_____
Other	☐	☐	☐	_____	_____	_____

If other, please specify: _____

5. ☐Yes ☐No **Do you think that you are allergic to any of these animals?**
   If yes, please check all that apply:
   ☐ Rats ☐ Mice ☐ Rabbits ☐ Guinea Pigs ☐ Monkeys ☐ Cattle
   ☐ Dogs ☐ Cats ☐ Hamsters ☐ Gerbils ☐ Prairie Dogs ☐ Dogs
   ☐ Sheep ☐Goats ☐ Swine ☐ Other (specify) _____
6. ☐Yes ☐No **Have you ever had any problems working around animals?**
   If yes, please explain: _____
7. ☐Yes ☐No **Do you currently experience problems working around animals?**
   If yes, please explain: _____
8. ☐Yes ☐No **Do you have any of the following symptoms when working with animals?**
   If yes, please check all that apply:
   ☐ Hand rash ☐ Other rash ☐Itchy eyes ☐ Watery eyes ☐ Runny nose ☐ Scratchy throat
   ☐ Cough ☐ Wheezing ☐ Trouble breathing ☐ Other (specify) _____
9. **Do you use or wear any of the following items when working with animals?**

Protective Eye Glasses	☐ Yes	☐ Sometimes	☐ No
Mask/Respirator	☐ Yes	☐ Sometimes	☐ No
Lab Coat	☐ Yes	☐ Sometimes	☐ No
Gloves	☐ Yes	☐ Sometimes	☐ No

10. **Are any agents of the following hazardous groups used in these animals?**
    ☐ Infectious ☐ Teratogenic/Carcinogenic ☐ Radioactive ☐ Other: _____
    Please list if checked: _____

(Print Name)

Allergy History

11. ☐Yes ☐No **Have you ever been skin tested for allergies?**
    If yes, what substances were you found to be allergic to or sensitized to?
    ☐ Ragweed ☐ Grass ☐ Trees ☐ Mold ☐ Mice
    ☐ Dust ☐ Cat ☐ Dog ☐ Other: _____

12. ☐Yes ☐No **Have you ever received allergy (desensitization/immunotherapy) shots?**

    If yes, what year did you receive the shots? _____

13. ☐Yes ☐No **Do any of your blood relatives (grandparents, parents, brothers/sisters) have allergies or asthma?**

14. ☐Yes ☐No **Are you allergic to latex?**

    If yes, please describe your symptoms. _____

15. ☐Yes ☐No **Do you have any indoor pets?**
    If yes, which animals and for how long?

Animal	1-2 Years	2-3 Years	3-4 Years	Over 4 Years
Dogs	☐	☐	☐	☐
Cats	☐	☐	☐	☐
Other (Type): _____	☐	☐	☐	☐

16. **What type of fuel do you use at home?**

    Cooking: ☐ Electricity ☐ Gas/propane ☐ Oil ☐ Wood ☐ Other _____

    Heating: ☐ Electricity ☐ Gas/propane ☐ Oil ☐ Wood ☐ Other _____

17. ☐Yes ☐No **Do you have roaches in your home?**

18. ☐Yes ☐No **Do you have non-pet mice or other animals in your home?**

Recombinant DNA

Certain medical conditions, such as immunosupression and pregnancy, increase your risk of potential health problems working with pathogens, recombinant DNA, and/or animals.

19. ☐Yes ☐No **Are you involved with recombinant DNA technology or microorganisms that contain recombinant DNA?**

20. ☐Yes ☐No **Does the research involve techniques in which viable, recombinant DNA-containing microorganisms are used to infect animals that require Bio-safety level 2 or 3 containment?**

    If yes, please explain: _____

21. ☐Yes ☐No **Do you have any diseases (lupus, cancer, etc.) that suppress your immune system?**

    If yes, please describe your symptoms. _____

22. ☐Yes ☐No **Do you currently take any mediations that may suppress your immune system?**

    If yes, please describe your symptoms. _____

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

    If yes, please describe your symptoms. _____

Other comments

24. _____
    _____
    _____

(Print Name)

Attestation and Signature

There may be increased occupational health risks associated with your job if situations change. At any time after completing this questionnaire,

if you become pregnant or if you start planning to become pregnant
or
if you become aware of a change in your health status
or
if the species of animal that you are exposed to at work changes

you are strongly encouraged to contact Employee Health to receive occupational health counseling, and/or evaluation.

☐Yes ☐No **I have been informed about the Saint Louis University Occupational Health Program**

☐Yes ☐No **I have had the opportunity to read the document "Safe Handling of Laboratory Animals."**

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

Signature: _____ Date: _____

(Print Name)

Instructions to Submit

Return completed form to Employee Health. It is best to use our secure confidential fax: 314-268-5537. You can keep the original for your own records after you check the fax confirmation from your machine. Alternatively, the form can be interoffice mailed to Employee Health. It is still recommended that you keep a copy for your own records.

CONFIDENTIAL Medical Information - SUBJECT TO HIPAA

Saint Louis University
Occupational Health Program for Laboratory and Animal Research

MEDICAL SERVICES DECLINATION FORM

Only Complete and Sign This Form if You Are Declining Medical Services in the Saint Louis University Occupational Health Program for Laboratory and Animal Research

The University and applicable research compliance committees (IACUC, IBC; RSC) must be assured that you are aware of the potential hazards associated with having contact with pathogens, recombinant DNA, and/or laboratory animals. Per University policy (RC-006), University personnel exposed to these hazards are required to participate in the Occupational Health Program for Laboratory and Animal Research (OHP). Persons required to participate in the OHP may decline the medical services component of the program. If you choose to decline the medical services, you are required to agree to the following:

1. I have been informed about the real and potential hazards associated with working with pathogens, recombinant DNA, and/or laboratory animals.
2. I attest that: (Check one)
   - ☐ I work with laboratory animals under Animal Use Protocol # _____;
     AND I have been informed of the Saint Louis University Occupational Health Program;
     AND I have had the opportunity to read the document "Safe Handling of Laboratory Animals."
   - ☐ I do not work with laboratory animals.
3. I knowingly decline the medical services offered in the Saint Louis University Occupational Health Program for Laboratory and Animal Research. I understand declining medical services could lead to, among other things, increased risk for health complications, inability to receive reimbursable care, and the need to secure my own alternate care provider for occupational health services.
4. I realize that declining the medical services of the Occupational Health Program may preclude me from some positions that require evaluation and preventative medical care.

IN SIGNING THIS FORM, I ACKNOWLEDGE AND REPRESENT THAT I have read the above Agreement, that I understand all its provisions, and I sign it voluntarily as my own free act and deed. I warrant that no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made.

_____	_____	_____
Date	OHP Participant (print)	OHP Participant (signature)

If Participant is Under 18 Years of Age

_____	_____	_____
Date	*Parent/Legal Guardian (print)*	*Parent/Legal Guardian (signature)*

Last Four Digits of Social Security#: XXX-XX- __ __ __ __

Date of Birth _____ Contact Phone Number: (____) ____-_____

Email Address: _____

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