Occupational Health and Safety Program
Laboratory Animal Resources

Binghamton University
State University of New York
P.O. Box 6000, Health Services In-204
(607) 777-4610, Fax: (607) 777-2881

Annual Health Screening Questionnaire for Faculty, Staff, and Students currently enrolled in the OH&S-LAR Program

****Confidential Medical Information****

(This information is strictly for the use of the Occupational Health and Safety Program for Laboratory Animal Resources and may not be released to anyone without your written consent.)

****Please return this form to Dr. Diane L. Paukett, D.O. at the above address for OH&S – LAR enclosed in an envelope marked confidential****

Section 1: Personal Information – Please Print

Contact Information

Last Name _____ First _____ Middle _____
Home Address _____ City _____ State _____ Zip _____
Campus Address _____
Campus Phone _____ Local phone or Cell phone # _____
Email _____ Birth Date _____ Sex: ☐M ☐F

In Case of an Emergency

Person to be notified _____ Relationship _____ Phone _____
Name of Primary Care Physician _____ Phone _____

University Department Information

Department _____ Investigator's Lab working in _____

Date of anticipated completion of undergraduate or graduate studies _____

Section 2: Risk Assessment

1. Employment Status

☐Animal Handler/Technician ☐Undergraduate Student ☐Graduate Student
☐Faculty ☐Other (list job description)

2. Please check all the animal species which you are working with at present

☐Rat ☐Mouse ☐Reptile ☐Bird ☐Rabbit ☐Other (list) _____

3. Please check the box below which approximates the time you plan to spend:

☐**Working in an animal lab** **and/or** ☐**Doing field work**

☐Daily **(List number of hours/day if changed from last yr.)** _____ ☐Weekly ☐Monthly
☐Rarely (Less than once a month)
☐Not handling animals but working in the Animal Laboratory environment (please explain) _____
_____

Section 3: Medical History Screening

Have you been told within the last year that you have any of the following conditions? (Please check all that apply)

1. ☐**Asthma** **(If yes)**

a. Is your Asthma under control with your present treatment? ☐**Yes** ☐**No**

b Are your Asthma symptoms triggered by any of the following? (Check all that apply) ☐**Allergies** ☐**Fumes** ☐**Cold** ☐**Heat** ☐**Other (Please describe)**_____

2. ☐**Allergies**

a. If there is a history of new Allergies please check all that apply:

☐Mold ☐Dust ☐Foods (List)_____ ☐Medications (List)_____

☐Pollens ☐Animals (List)_____

b. Any new symptoms from existing Allergies? ☐**Yes** ☐**No**

(If yes, please explain)_____

c. Any new allergy to Latex or another type of gloves? ☐**Yes** ☐**No**

d. Within the past year have you had an anaphylactic reaction? ☐**Yes** ☐**No**

3. ☐**Heart disease** (**If yes, please explain)**_____

4. Any changes in your immune status within the past year? ☐Yes ☐No

a. **If yes, please explain**_____

b. Are you currently on immunosuppressive medication? ☐**Yes** ☐**No**

5. **Are you presently being treated for any acute or chronic illness?** ☐Yes ☐No

If yes, please explain:_____

6. **(For females only) are you pregnant?** ☐**Yes** ☐**No**

7. **Have you received the following immunizations within the past year?** (If so, please list date of most recent vaccinations or boosters) ☐**Tetanus**_____ ☐**Hepatitis B**_____

8. Do you presently have any work restrictions? ☐Yes ☐No

(If yes, please explain):_____

9. Have you developed any of the following symptoms within the last year? (Check all that apply)

☐Chronic cough ☐Wheezing ☐Night-time cough

☐Itchy or irritated eyes ☐Hives ☐Skin rash

10. Do you have any new symptoms that have developed over the last year which you feel may be related to your work environment? ☐**Yes** ☐**No**

(If yes, please explain)_____

I attest that the information above is correct to the best of my knowledge.

I understand and give my permission for this information to be entered in a Confidential, centralized database for purposes of reducing risk of exposure to relevant vaccine preventable diseases, allergens, zoonotic diseases, and bloodborne pathogens.

Signature_____ **Date**_____

_____**Date Reviewed**