Corporate Health Services
Northwestern Medical Group
312.926.8282 (Chicago)
847.535.6172 (Lake Forest)
northwesternmedicine.org

HEALTH QUESTIONNAIRE
FOR WORKERS IN ANIMAL FACILITIES

Please complete every item of this questionnaire. "N/A" is not an acceptable answer – instead, please mark the "none" option or write "no" as appropriate. **Do not leave anything blank**. The information provided in this questionnaire is strictly confidential and will not be released to Northwestern University or to any other agency without the explicit consent of the employee.

PATIENT INFORMATION

Name: _____ **Birth Date:** _____

Phone Number: _____ **Social Security Number:** _____

Address: _____ **City, State, Zip:** _____

Email: _____ **Sex:** ☐ Male ☐ Female

JOB INFORMATION

Job Category: ☐ Animal Care Worker ☐ Researcher ☐ Veterinary ☐ Administrative
☐ Other: _____

1. Please list the animals with which you will be working: ☐ None

2. Please list the type of contact (if any) you've had in the past with these types of animals: ☐ None

3. Please list any reactions you've had to animals? ☐ None

4. Please list the agents with which you will be working (including radiation, chemicals, cleaning products, etc.): ☐ None

HEALTH INFORMATION

5. Please list any medications that you are using: ☐ None

6. Please list any medication allergies: ☐ None

7. Please list any previous hospitalizations or surgeries: ☐ None

8. Please list any history of chronic rhinitis or sinusitis, asthma, eczema, hives, skin rashes, tongue/throat swelling, anaphylaxis, or positive allergy testing: ☐ None

9. Please list any history of immunosuppression from medication or medical condition. Examples include HIV/AIDS, cancer, lymphoma, myeloma, chronic steroid use, organ/bone marrow transplantation, sick cell anemia, and spleen injury. ☐ None

Corporate Health Services
Northwestern Medical Group
312.926.8282 (Chicago)
847.535.6172 (Lake Forest)
northwesternmedicine.org

HEALTH QUESTIONNAIRE (continued)

10. Please list any history of heart disease, lung disease, chronic liver disease, chronic kidney disease, or spleen removal: ☐ None

11. Please list any work restrictions you are currently on due to your health: ☐ None

12. For workers with animal contact- Please list any problems lifting the cages or pushing/pulling the platforms: ☐ None

13. Do you have a known latex allergy diagnosed by a medical professional? ☐ Yes ☐ No

14. Are you currently experiencing:

Unexplained fatigue, weight loss, or lack of energy?	☐ Yes	☐ No
Unexplained fever, chills, night sweats, or lymph node enlargement?	☐ Yes	☐ No
Severe headaches, visual changes, hearing loss, blackouts, dizziness, weakness, or numbness?	☐ Yes	☐ No
Depression, anxiety, memory loss, irritability, or uncontrolled temper?	☐ Yes	☐ No
Shortness of breath at rest or with activity?	☐ Yes	☐ No
Wheezing, persistent cough, sputum production, or coughing up of blood?	☐ Yes	☐ No
Unexplained chest pains, palpitations or swelling of the feet?	☐ Yes	☐ No
Persistent nausea, vomiting, abdominal pain, or diarrhea?	☐ Yes	☐ No
Rashes, hives, angioedema, anaphylaxis, or other allergic problems?	☐ Yes	☐ No
Muscle aches, tremors or weakness?	☐ Yes	☐ No
Swollen and painful joints?	☐ Yes	☐ No
Pain with bending stooping or kneeling?	☐ Yes	☐ No
Hearing problems or ringing in the ears?	☐ Yes	☐ No
Other (please list and describe):	☐ Yes	☐ No

If you answered "yes" to any of the above items, please provide details here. Please be as specific as possible:

15. Have you had a tuberculosis test in the last year? ☐ Yes ☐ No

16. Date of last tetanus vaccine: _____ ☐ Tetanus/Diphtheria/Pertussis ☐ Tetanus/Diphtheria

Have you received a Pertussis booster as an adult? ☐ Yes ☐ No

17. Have you received the Rabies vaccination series? ☐ Yes ☐ No

If "Yes," please provide the date you completed the series: _____

Reason for being vaccinated: ☐ Post-Exposure ☐ Pre-Exposure

18. <u>CCM ONLY</u>: Please list any current or historical problems with your back/neck: ☐ None ☐ ACUC Employee (Exempt)

19. <u>CCM ONLY</u>: Please list any current or historical problems with your joints (including shoulders, knees, wrists, or ankles): ☐ None ☐ ACUC Employee (Exempt)

20. I have completed the above questionnaire honestly and completely.

_____ _____

Signature **Date**