Oklahoma State University
Animal, Biological, Chemical, and Radioactive Material Questionnaire

Please answer all questions. This questionnaire will be kept on file ONLY in your Employee Health record.
Information provided on this medical questionnaire is protected by HIPAA.

Date: ___________________________________ Date of Birth ______________________

Name: ____ Gender __________________________
PLEASE PRINT (Last, First, Middle initial)

Credentials: _________________ (MD, DO, PhD, MS, RN, etc.) Employee #: ______________________

Title: ____ Supervisor _______________________

Employee Department: ______________________________________ Email ____________________________

Phone # (work): ________________________ Fax #: __________________ Mail Route ________________

Travel outside the U.S. in the past twelve months **yes** **no**

Explain: ____

Biological Material in Lab **yes** **no**

Biosafety Level of Lab:
1 2 3 4

Date you began working in this lab: _______________________

Chemical Handling in Lab

What frequency are you handling chemicals: Daily Weekly Monthly Infrequently

Radioactive Material Handling in Lab **yes** **no**

What frequency are you handling radioactive material: Daily Weekly Monthly Infrequently

Animal Handling/Animal in Lab **yes** **no**

Animal Biosafety Level: 1 2 3 4

Which animal/insects are in the lab? Check all that apply: Birds Cats Dogs Ferrets Frogs Non-Human Primates Pigs Rabbits Reptiles Rodents Sheep

Other (please list): ____

Venomous Snakes/Lizards (list names and antivenin): ____

Insects: Mosquitoes Ticks Fleas

Will you be handling animal excreta? **yes** **no**

What IACUC protocol(s) are you working with and where (please list all the protocols and the PI for the protocol you will be working on):____

MEDICAL HISTORY

Medications currently taking:

Allergies to medicines:

Other allergies:

Please check all that apply to you and circle the frequency:

Vision:

☐	Eye irritation/redness	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Watering eyes	Frequency of problem:	1-2/month	1-2/week	≥ 3/week

Nose/Throat:

☐	Sore throats	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Colds	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Sinus problems/ nasal congestion/runny nose	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Hay fever/nose allergies/ allergic rhinitis	Frequency of problem:	1-2/month	1-2/week	≥ 3/week

Lungs

☐	Chronic cough	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Asthma				
☐	History as a child	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	As an adult	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Bronchitis	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Pneumonia	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Tuberculosis	What year? _____________			
☐	Abnormal chest x-ray	What year? _____________			
☐	Abnormal breathing tests	What year? _____________			

Stomach/Liver/Colon:

☐	Hepatitis in past	What year? _______________			
☐	Frequent diarrhea	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Irritable bowel	Frequency of problem:	1-2/month	1-2/week	≥ 3/week

Blood/Lymph System/Cancer

☐	Low red cell count/anemia	What year? _______________			
☐	Bleeding problem	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Low white cell count	What year? _______________			
☐	Swollen lymph glands	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Easy bruising	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Immunological disease	Diagnosis:			

Endocrine System

☐	History of diabetes	Date of diagnosis: ______________________________			
☐	Thyroid disease	Any history of radioisotope therapy?		YES	NO

Skin:

☐	Rash	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Eczema	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Contact dermatitis from:	______________________________			

General

☐	Unexplained fever	Frequency of problem:	1-2/month	1-2/week	≥ 3/week
☐	Night sweats	Frequency of problem:	1-2/month	1-2/week	≥ 3/week

IMMUNIZATION AND SCREENING HISTORY

(If you know this is documented in your OSU Employee Health record, please indicate so below)

Immunization/ Screen	Date	Date	Date	Date	Titer drawn	Titer results	History of Disease/Year
Anthrax							
BCG					---	---	---
Eastern equine encephalitis					---	---	
Francisella tularensis							
Hepatitis B							
Japanese encephalitis							
Measles, Mumps, Rubella							
Rabies							
Rift Valley fever							
Smallpox							
TB Test							
Tetanus/diphtheria							
Tick-borne encephalitis							
Tularemia							
Venezuelan equine encephalitis							
Western equine encephalitis							
Yellow Fever							
Yersinia pestis							

EXPOSURE SURVEY

Have you been exposed to any of the following:	NO	YES currently	YES in the past	Symptoms at exposure	Any co-workers with symptoms?
Metals					
Dust or fibers					
Chemicals					
Fumes					
Radiation					
Loud noise					
Vibration					
Extreme heat or cold					
Biological agents					

If you answered YES to any of the items in the Exposure Survey, describe your exposure in detail—how you were exposed, and to what were you exposed. (*If you need more room, use the back of the page*.)

WORK HISTORY/OCCUPATIONAL PROFILE

Fill in the table below listing all jobs you have worked including short-term, seasonal, part-time employment and military service. Begin with the most recent job. (*Use the back of the page if you need more room*.)

Dates of employment	Company/Job title and description of work	List materials you worked with: (chemicals, dust, fibers, biological agents, radioactive agents, physical agents, metals, etc.)	Protection Equipment (PPE)

Signature: Date: