



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.) CWID #: _____

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: Date you began working in this lab: _____
 1 2 3 4

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 or outside Lab **yes** **no**

Animal Biosafety Level: 1 2 3 4
 Which animal are you working with? Check all that apply: Birds Cats Dogs Cattle Horses
 Non-Human Primates Pigs Rabbits Reptiles Rodents Sheep Ferrets Frogs Goat

Other (please list): _____

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

Insects: Mosquitoes Ticks Fleas Other

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:

- | | | | | |
|---|-----------------------|-----------|----------|----------|
| <input type="checkbox"/> Eye irritation/redness | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Watery eyes | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |

Nose/Throat:

- | | | | | |
|---|-----------------------|-----------|----------|----------|
| <input type="checkbox"/> Sore throats | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Colds | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Sinus problems/
nasal congestion/runny nose | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Hay fever/nose allergies/
allergic rhinitis | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |

Lungs

- | | | | | |
|---|-----------------------|-----------|----------|----------|
| <input type="checkbox"/> Chronic cough | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Asthma | | | | |
| <input type="checkbox"/> History as a child | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> As an adult | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Bronchitis | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Pneumonia | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Tuberculosis | What year? _____ | | | |
| <input type="checkbox"/> Abnormal chest x-ray | What year? _____ | | | |
| <input type="checkbox"/> Abnormal breathing tests | What year? _____ | | | |

Stomach/Liver/Colon:

- | | | | | |
|--|-----------------------|-----------|----------|----------|
| <input type="checkbox"/> Hepatitis in past | What year? _____ | | | |
| <input type="checkbox"/> Frequent diarrhea | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Irritable bowel | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |

Blood/Lymph System/Cancer

- | | | | | |
|--|-----------------------|-----------|----------|----------|
| <input type="checkbox"/> Low red cell count/anemia | What year? _____ | | | |
| <input type="checkbox"/> Bleeding problem | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Low white cell count | What year? _____ | | | |
| <input type="checkbox"/> Swollen lymph glands | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Easy bruising | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Immunological disease | Diagnosis: _____ | | | |

Endocrine System

- | | | | | |
|--|--------------------------------------|-----|----|--|
| <input type="checkbox"/> History of diabetes | Date of diagnosis: _____ | | | |
| <input type="checkbox"/> Thyroid disease | Any history of radioisotope therapy? | YES | NO | |

Skin:

- | | | | | |
|---|-----------------------|-----------|----------|----------|
| <input type="checkbox"/> Rash | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Eczema | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> Contact dermatitis from: | _____ | | | |

General

- | | | | | |
|--|-----------------------|-----------|----------|----------|
| <input type="checkbox"/> Unexplained fever | Frequency of problem: | 1-2/month | 1-2/week | ≥ 3/week |
| <input type="checkbox"/> 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
<i>Anthrax</i>							
<i>BCG</i>					---	---	---
<i>Eastern equine encephalitis</i>					---	---	
<i>Francisella tularensis</i>							
<i>Hepatitis B</i>							
<i>Japanese encephalitis</i>							
<i>Measles, Mumps, Rubella</i>							
<i>Rabies</i>							
<i>Rift Valley fever</i>							
<i>Smallpox</i>							
<i>TB Test</i>							
<i>Tetanus/diphtheria</i>							
<i>Tick-borne encephalitis</i>							
<i>Tularemia</i>							
<i>Venezuelan equine encephalitis</i>							
<i>Western equine encephalitis</i>							
<i>Yellow Fever</i>							
<i>Yersinia pestis</i>							

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?
<i>Metals</i>					
<i>Dust or fibers</i>					
<i>Chemicals</i>					
<i>Fumes</i>					
<i>Radiation</i>					
<i>Loud noise</i>					
<i>Vibration</i>					
<i>Extreme heat or cold</i>					
<i>Biological agents</i>					

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: