CONFIDENTIAL
For Review by Designated Medical Clinician Only

San Francisco State University
LABORATORY ANIMAL OCCUPATIONAL HEALTH SCREENING
INITIAL QUESTIONNAIRE

This ***confidential*** questionnaire requests important work/training and medical information from persons who may come in direct contact with animals at SFSU. Please complete this questionnaire and provide it to the SFSU Human and Animal Protections in a sealed envelope, signed across the flap. HAP will forward the sealed envelope to the SFSU's designated medical reviewer. You may be contacted by the reviewer for additional information if incomplete or further explanation is needed. Some persons may be asked to complete a physical examination based upon their work exposures and this questionnaire after review by the occupational health clinician.

Name: _____
Position (e.g., faculty, staff, student): _____
Work Phone: _____ Home or Cell Phone: _____
Email: _____ Best time to contact you _____
Supervisor/advisor or instructor: _____
Their work phone:_____ Email: _____

1. LABORATORY ANIMAL USE

A. Please describe your work/study tasks at SFSU with animals or their tissues. If not known please request this information from your hiring supervisor/instructor: _____
_____
_____

B. Do you use or wear any of the following personal protection in your work with animals?

Safety glasses/goggles	☐ Yes ☐ No
Lab coat/coveralls	☐ Yes ☐ No
Gloves	☐ Yes ☐ No
Hair cover	☐ Yes ☐ No
Mask (surgical type)	☐ Yes ☐ No
Respirator (N95 type or other)	☐ Yes ☐ No

C. How many years (total) have you worked with or around lab animals? _____

ANIMAL EXPOSURE INVENTORY (*Check ALL* that apply)

	Average **Frequency of Contact**				**Types of Exposure**		
Animal Exposure (Include work, home, hobby)	Daily	Weekly	Monthly	Hours per day or week	Live Animals	Dead Animals / Tissues	Dirty Bedding/ Cage Changing
RATS							
MICE							
RABBITS							
REPTILES (List):							
FROGS XENOPUS							
FISH							
OTHER (List):							

2. PERSONAL HEALTH HISTORY

A. IMMUNIZATIONS

Check ALL previous immunizations you have had and give the year you last had them:

	YEAR
☐ Tetanus (recommended every ten years)	_____
☐ Rabies (three shots required)	_____
Number of shots _____	
☐ Other (list:_____)	_____

B. ENVIRONMENTAL ALLERGIES /ASTHMA

	Yes	No	Don't know
1. Do you have or have you EVER had allergies such as:			
• Seasonal allergies / Hayfever? (Sneezing, runny nose, itchy eyes)	☐	☐	☐
• Skin eczema/Hives (Allergic skin rash)?	☐	☐	☐
• Asthma? (Attacks of wheezing, shortness of breath, cough)	☐	☐	☐
• Anaphylaxis (Severe shock-like allergic reaction)?	☐	☐	☐
2. Are you allergic to any animal(s)? If YES, list animals that cause your allergy symptoms: _____	☐	☐	☐
3. Do you have allergy symptoms or asthma specifically related to animals that you may work with at SFSU? If YES, list animal & symptoms:_____ _____	☐	☐	☐
4. Have you ever had allergy testing (skin or blood tests)? If YES, list positive tests: _____ _____	☐	☐	☐
5. Do you have any animals at home (indoors)? If YES, please list: _____	☐	☐	
6. Do you have any skin problems related to work, glove use? (Reactions to latex; dry, cracked skin; rashes to animals) If YES, describe: _____ _____	☐	☐	☐

7. List any treatments that you receive to relieve your allergies, including over-the–counter or alternative therapies (e.g., medication, shots):

_____
_____

8. Have you ever developed allergy symptoms (e.g., sneezing, cough, rash) or illnesses (e.g., infections) as a result of any contact with or being around animals at work or home? ☐ Yes ☐ No

If YES, please describe: _____

_____

C. MEDICAL CONDITIONS

	Yes	No
1. Diabetes	☐	☐
2. Chronic Kidney or Liver Disease	☐	☐
3. Other Chronic Infection or Immune Disorder	☐	☐
4. Pregnancy or attempting pregnancy	☐	☐

D. OTHER

	Yes	No
1. Do you have any health or workplace concerns not covered by this questionnaire that you would like to confidentially discuss with the clinician?	☐	☐

Please read the following and sign and date before submitting:
The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

_____
Signature of Participant Date

DO NOT WRITE BELOW THIS AREA. FOR CLINICIAN USE ONLY.

Form reviewed by: _____ _____
Clinician Date

Participant contacted: YES NO _____
Date

Comments/Recommendations/Referral: _____

_____