

STANFORD UNIVERSITY

LABORATORY ANIMAL OCCUPATIONAL HEALTH SURVEILLANCE PROGRAM (LAOHP) HEALTH QUESTIONNAIRE

Name (Last, First, M.I.)		University ID	Date of Birth
Home Address		Home Phone	Today's Date
Job Title	Work Phone	E-mail	
PI/ Supervisor		Department	Temporary Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No

INSTRUCTIONS:

- 1) Fill in any missing personal information above
- 2) Complete Questionnaire - Part A and B
- 3) Send all parts to: Occupational Health Center / OHC, 480 Oak Road - MC: 8007;
Phone: 650-725-5308; FAX: 650-725-9218

PART A: OCCUPATIONAL / ENVIRONMENTAL RISK FACTORS

- I am involved with research with human cells, blood, body fluids

I. LABORATORY ANIMAL USE

Check boxes if statement is applicable to your status: *(check all that apply)*

- I will not be working with **or** around animals *(If checked, stop here and return this page).*
- I am involved with veterinary care or animal husbandry.
- I am involved with research of animals or animal tissues
- I work in the Department of Comparative Medicine

Animals/Tissues/Body Fluids (check all that apply)

Frequency of Exposure

	<u>Daily</u>	<u>1-4 times/ Week</u>	<u>1-3 times/ month</u>	<u>Infrequent (1- 11 times/year)</u>
<input type="checkbox"/> Rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <u>Wild</u> Rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rabbits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Birds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Marine Mammals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reptiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Goats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sheep <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Non-human primates:				
<input type="checkbox"/> Squirrel Monkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chimp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Macaque, (Rhesus, Cynomolgus etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Macaque or Macaque tissues from outside of Stanford University	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify source: _____				
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Human Specimens* (cells, blood, body fluids, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH QUESTIONNAIRE

Name (Last, First, M.I.)

SUNet ID

II. RISK ASSESSMENT FOR LABORATORY ANIMAL USE

Provide the following for each agent you are exposed to in conjunction with animal studies:

- | | Yes | No | If yes, specify |
|------------------------------------------|--------------------------|--------------------------|-----------------|
| a. Infectious Agents | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b. Human Monoclonal Antibodies | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c. Anti-Neoplastic Agents (Chemotherapy) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| d. Other | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

PART B: PERSONAL HEALTH HISTORY

I. IMMUNIZATION

Have you ever had or do you now have any of the following immunizations (vaccinations) or diseases?

	Immunization (Most Recent)				Disease		
	Yes	Year	No	Don't Know	Yes	Year	No
Tetanus							
Pre-Exposure Rabies (series of 3 & usually veterinarians or high risk individuals)							

II. ENVIRONMENTAL ALLERGIES/ ASTHMA

- | | <u>Yes</u> | <u>No</u> | <u>Don't know</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Are you allergic to any animal(s)?
If yes, list animals that cause your allergy symptoms:
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any other known allergies?
If yes, what? _____
List cause(s) of allergies?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. List symptoms that occur when you are suffering from your allergies:
_____ | | | |
| 4. List treatment that you receive to relieve your allergies:

_____ | | | |
| 5. Do you have asthma?.....
If yes, list cause(s) of asthma (<i>if you do not know, write "UNKNOWN"</i>):
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have allergy symptoms or asthma specifically related to animals that you currently work with?
If yes, have you been seen by a physician for this?
List symptoms:
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any skin problems related to work (e.g., reactions to latex gloves; dry, cracked skin; rashes)?
If yes, describe:
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you experience shortness of breath at work?
If yes, explain:
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you wear a fit tested respirator to perform any activities at work?
If yes, Date of last respirator clearance medical questionnaire/evaluation: _____
Date of last respirator training: _____
Date of last respirator fit testing: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

For more information on the Stanford Respiratory Protection Program, please call OHC, 725-5308

HEALTH QUESTIONNAIRE

Name (Last, First, M.I.)

SUNet ID

PART B (CONTINUED): PERSONAL HEALTH HISTORY

III. ADDITIONAL PERSONAL HEALTH CONCERNS

- | | <u>Yes</u> | <u>No</u> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the Occupational Health Clinicians or your personal care physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any diseases causing immune suppression that you would like to discuss with the Occupational Health Clinician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you a member of the Department of Comparative Medicine?
<u>Only if yes, answer questions in Section IV</u> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you work with non-human primates or non-human primate tissues?.....
<u>Only if yes, answer questions in Section IV and V</u> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you work with human blood, blood products, body fluids, cell lines or tissues, chimps / chimp blood or tissue?.....
<u>Only if yes, answer questions in Section V</u> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you work with sheep or sheep tissues?
<u>Only if yes, answer questions in Section VI</u> | <input type="checkbox"/> | <input type="checkbox"/> |

IV. FOR INDIVIDUALS WORKING IN THE DEPARTMENT OF COMPARATIVE MEDICINE OR NHP

1. Tuberculosis Surveillance
 - a. Have you ever lived in countries other than the United States?.....
If yes, list countries and duration: _____
 - b. Have you had active tuberculosis?
If yes, list year and description of treatment: _____
 - c. What is the date of your last tuberculosis skin or blood test? _____
 - d. Results of TB skin test or tuberculosis blood test (Quantiferon Gold): Positive Negative
 - e. Have you received the tuberculosis vaccine Bacillus Calmette Guerin (BCG) vaccination? (Note: this is not given in the United States)
If yes, year of vaccination: _____
 - f. If you have received BCG, have you had a tuberculin skin test or blood test (Quantiferon Gold) since the vaccination?
If yes, year of skin test: _____
Results: Positive Negative
 - g. Date of last chest x-ray: _____
Reason x-ray was taken: _____
Results: _____

IV. FOR INDIVIDUALS WORKING WITH NON-HUMAN PRIMATES OR NON-HUMAN PRIMATE TISSUES

- | | <u>Yes</u> | <u>No</u> | <u>Don't Know</u> |
|-------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Have you had naturally-acquired measles (rubeola)?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had measles immunizations?.....
If yes, approximate date of vaccination(s) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

V. FOR INDIVIDUALS WORKING WITH CHIMPS OR HUMAN SPECIMENS (CELL LINES, TISSUE, BLOOD, BODY FLUIDS, ETC.)

- | | <u>Yes</u> | <u>No</u> | <u>Don't Know</u> |
|------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Have you had Hepatitis B immunization? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, a. approximate date/year of vaccinations: _____ | | | |
| b. have you had a Hepatitis B titer showing immunity?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please provide a copy of your results to OHC <input type="checkbox"/> already provided | | | |
| 2. Have you ever had Hepatitis B disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, year: _____ | | | |

HEALTH QUESTIONNAIRE

Name (Last, First, M.I.)

SUNet ID

PART B (CONTINUED): PERSONAL HEALTH HISTORY

VI. FOR INDIVIDUALS WORKING WITH SHEEP

- | | <u>Yes</u> | <u>No</u> |
|-------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you work with female sheep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a history of known valvular disease (heart murmurs) or congenital heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date of diagnosis: _____ | | |
| Type of disease: _____ | | |
| Treatment: _____ | | |
| 3. Do you now have or have you ever had Q-fever? | <input type="checkbox"/> | <input type="checkbox"/> |

I have answered the questions on this form truthfully and to the best of my recollection.

Signature

Date