

ANIMAL HANDLER & USERS MEDICAL QUESTIONNAIRE

This CONFIDENTIAL medical history form must be completed on initial enrollment and yearly thereafter as part of WPI's Occupational Health Program.
Please answer all questions completely. Mail or take this questionnaire (marked *Confidential*) to:
Occupational Health, Reliant Health Care ; 630 Plantation St; Worcester MA 01605; 508-853-2854

Indicate One: **Initial** ____ **Annual** ____

Name _____ Date of birth _____

Status: Faculty Staff
 Undergraduate Student Graduate Student

Phone #: _____

1. In your lab, are you in contact with laboratory or wild animals? Yes ____ No ____
List what type(s) of animal(s) _____
Length of exposure time per day and/or week _____
2. Do you work with infectious agents or any other biological hazard? Yes ____ No ____
If "Yes," list type: _____
How many hours per week do you work with these agents? _____
3. In the lab, do you work with carcinogens, any other toxic hazardous substances, or animals to which carcinogens or toxic substances have been administered?
Yes ____ No ____ If "Yes," List what type: _____
4. Are you required to lift more than 20 pounds on a frequent basis? Yes ____ No ____
5. In the lab, do you wear personal protective equipment? Yes ____ No ____
If "Yes," list what type: _____
6. Do you change or shower before leaving the lab? Yes ____ No ____
7. Have animals in the lab ever bitten you? Yes ____ No ____
If "Yes," list what animals _____
8. Do you have any contact with animals outside of the lab? Yes ____ No ____
If "Yes," list what animals _____
If "Yes", how many hours per day on average? _____
9. Do you currently have any of the following symptoms?

Itchy eyes	Yes ____ No ____	Runny nose	Yes ____ No ____
Cough	Yes ____ No ____	Chest tightness	Yes ____ No ____
Wheeze	Yes ____ No ____	Skin rash	Yes ____ No ____
10. Do you currently or have you ever smoked? Yes ____ No ____
If "Yes," for how long? _____
How many packs per day do you/have you smoked? _____
When did you quit smoking? _____

11. Immunization history	Date Received
Tetanus	_____
<i>It is highly recommended your immunizations be kept current, especially Tetanus.</i>	
Rabies	_____
Hepatitis B series	_____
BCG	_____
Tuberculosis PPD Result + / -	_____

12. Do you have or have you ever had:

Medication allergy/sensitivity	Yes ___ No ___
List _____	
Food allergy/sensitivity	Yes ___ No ___
List _____	
Hay fever	Yes ___ No ___
Asthma	Yes ___ No ___
Insect / Animal / Plant Allergies	Yes ___ No ___
List _____	
Skin tests for allergies	Yes ___ No ___
List _____	
Tuberculosis	Yes ___ No ___
Hepatitis	Yes ___ No ___
List type and for how long regardless if A, B, or C _____	

13. Do you have any chronic illness (e.g., high BP, diabetes)? Yes ___ No ___

List _____

14. Are you currently taking prescription/over-the-counter medications? Yes ___ No ___

List _____

15. Are you pregnant or planning to become pregnant this academic school year?

N/A ___ Yes ___ No ___

16. Do you want to talk to an Occupational Healthcare Specialist? Yes ___ No ___

Signature _____ Date _____

Return completed form to: **Occupational Health; Reliant Health Care**
630 Plantation Street
Worcester, MA 01605