

Annual Health Surveillance Questionnaire

Confidential: For Occupational Health Use Only

Return the completed form to ASU Employee Health at mail code 3011 or email to employeehealth@asu.edu

This form is to be used by individuals who have previously completed an Occupational Health and Safety Program Health Surveillance Questionnaire.

Name — last, first, MI	ASU ID	ASURITE
Home address	Cell phone	Date of birth
	Today's date	
Job title	E-mail	
Role	Department	
Supervisor	Supervisor email	
Principal investigator — if different from supervisor		

Part A: Occupational or environmental risk factors

1. Laboratory animal use

Animals, tissues or body fluids used or handled	Frequency of contact			
	Daily	1–3 times per week	1–3 times per month	Infrequent — 1–6 times per year
Check all that apply				
<input type="checkbox"/> Amphibians, reptiles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bats, including wild bats.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Birds, including wild birds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cattle, sheep, goats.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Marine and freshwater fish.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nonhuman primates, monkeys — NHPs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Poultry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rabbits, dogs, cats.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rodents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Swine.	<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"/>

2. Risk assessment for laboratory animal use

Are you exposed to any of the following in conjunction with animal studies?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Biohazardous materials, including infectious agents. |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Recombinant or synthetic DNA technologies. |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Chemical carcinogens. |
| <input type="checkbox"/> | <input type="checkbox"/> | D. Radiation. |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Anti-neoplastic agents. |
| <input type="checkbox"/> | <input type="checkbox"/> | F. Known reproductive hazards or teratogens. |
| <input type="checkbox"/> | <input type="checkbox"/> | G. Human-derived materials — specimens, cells, bodily fluids, etc.* |
| <input type="checkbox"/> | <input type="checkbox"/> | H. Sharps — needles, scalpels, razor blades, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | I. Other. |
- If yes, specify:

***Note:** If you answered **yes** to working with human-derived materials (G), you are required to complete the **Hepatitis B Consent/Declination Form** acknowledging the understanding of the risks of working with human materials. Please disregard if you have already completed this form.

Part B: Personal health history

1. Infectious disease and immunization history

Vaccinations may be required and recommended depending upon the agent or toxin and the availability of the vaccination at the discretion of IACUC, the laboratory and ASU Employee Health.
All individuals must have had a Tetanus vaccination within the last 10 years and the vaccination must be valid for at least one year from the date of the questionnaire.

For individuals who are working with **NHPs**: Two measles, mumps and rubella —MMR— vaccinations in a lifetime, or a current positive measles titer and annual Tuberculosis — TB — screening is required.

Medical history

Do you have any other pertinent medical history? Yes No

If yes, explain. _____

2. Environmental allergies or Asthma

Yes	No	Don't Know	Do you exhibit any of the following symptoms — runny nose, itchy watery eyes, rashes, shortness of breath or difficulty breathing — when exposed to:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals? If yes, which animals? What are your symptoms? What is the severity of your symptoms — mild, moderate, severe? List the treatment you use to relieve your allergy symptoms. Do you have an epi-pen? Do you wear a mask or respirator?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental allergens — pollen, mold, dust? What are your symptoms? What is the severity of your symptoms — mild, moderate, severe? List the treatment you use to relieve your allergy symptoms. Do you have an epi-pen? Do you wear a mask or respirator?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals? If yes, which chemicals? List the treatment you receive to relieve your allergies.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are there any other laboratory exposures not listed above? If yes, please list below:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Asthma? Asthma or allergy medications? List the treatment you use or receive to relieve your Asthma symptoms.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any skin problems related to work, e.g., reactions to latex gloves? If yes, describe. What are your symptoms? What is the severity of your symptoms — mild, moderate, severe? List the treatments you use to relieve your skin irritation symptoms.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any additional allergies — food, medications, eggs, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you answered yes to any of the above questions, has the problem worsened over the past year? If yes, please explain:

Part C: Medical surveillance

Have you had to visit the ASU employee Health or another healthcare provider during the past year for any of the following reasons: If yes to any question, please provide details.

Yes	No	If yes to any question, please provide details.
<input type="checkbox"/>	<input type="checkbox"/>	Injuries at work?
<input type="checkbox"/>	<input type="checkbox"/>	Illness related to work, e.g., an Asthma attack, allergy flare-up, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Contact with or exposure to a potentially hazardous substance, e.g., a puncture wound from a laboratory instrument or some other device, exposure to an infectious agent, exposure to a chemical agent, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Rash or other skin problems?
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problem?
<input type="checkbox"/>	<input type="checkbox"/>	Other, please specify.

3. Additional personal health concerns

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Do you perform work in the field related to animal use?
<input type="checkbox"/>	<input type="checkbox"/>	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 ASU Employee Health?

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

I, _____, give my permission to ASU Employee Health — including any health care professional appointed by ASU Employee Health and directly involved in my care — and the ASU Institutional Animal Care and Use Committee — IACUC — to exchange medical information concerning me when necessary to coordinate my medical care. I understand this exchange is for the purpose of coordinating a safe work environment and to assure compliance with policies as adopted by the IACUC.

This release does not entitle other offices or departments of Arizona State University including, but not limited to, academic departments or the ASU Police to obtain information about me, unless those offices are otherwise entitled to the information or unless I specifically approve the release of such information in writing. I may revoke this release at any time in writing, but I understand that revocation will not affect any release made prior to the revocation.

Signature

Date