

**Initial 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](mailto:employeehealth@asu.edu)

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.

**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 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.

Please complete the following table and provide documentation of vaccine and blood work history — titers — as required.

If you were born before 12/31/56, you do not need to provide proof of MMR vaccinations but must provide proof of tetanus vaccination received within the last 10 years.

	Immunizations or titers			Disease	
	Yes	Years	No	Yes	Years
Tetanus — Tdap or Td.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
MMR #1 — series of two required: measles, mumps, rubella	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
MMR #2 — second vaccination.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
MMR titer.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

**Medical history**

**Have you had any of the following?** Check all that apply and **indicate when**.

- Pneumonia       Restriction on lifting limit      specify lbs.  
 Recurrent Bronchitis       Chronic back or joint pain       Heart disease  
 Repetitive Motion Injury  
 Other pertinent medical history:

**2. Environmental allergies or Asthma**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you exhibit any of the following symptoms — runny nose, itchy watery eyes, rashes, shortness of breath or difficulty breathing — when exposed to: <b>Animals?</b> 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"/>	<b>Environmental allergens — pollen, mold, dust?</b> 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"/>	<b>Chemicals?</b> If yes, which chemicals? List the treatment you receive to relieve your allergies.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you have Asthma?</b> 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"/>	<b>Do you have any skin problems related to work, e.g., reactions to latex gloves?</b> 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"/>	<b>Do you have any additional allergies — food, medications, eggs, etc.?</b>

**3. Additional information for high risk employees or students — those using primates, sheep or goats.**

**Nonhuman primate users only**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	1. Tuberculosis Surveillance
<input type="checkbox"/>	<input type="checkbox"/>	a. Have you ever lived in countries other than the United States? If yes, list countries.
<input type="checkbox"/>	<input type="checkbox"/>	b. Have you had active tuberculosis or been diagnosed with latent Tuberculosis? If yes, list year and describe treatment. Proceed to item h. If no:
<input type="checkbox"/>	<input type="checkbox"/>	c. Date of last tuberculosis — TB — skin test:
<input type="checkbox"/>	<input type="checkbox"/>	d. Result of TB skin test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<input type="checkbox"/>	<input type="checkbox"/>	e. Have you received the tuberculosis vaccine Bacillus Calmette Guerin — BCG? If no, proceed to item h.
<input type="checkbox"/>	<input type="checkbox"/>	f. If you have received BCG, have you had a tuberculin skin test since the vaccination? If no, proceed to item h.
<input type="checkbox"/>	<input type="checkbox"/>	g. If you have had a tuberculin skin test since a BCG vaccination, what were the results? <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<input type="checkbox"/>	<input type="checkbox"/>	h. Date of last chest x-ray: Reason x-ray was taken:

**Sheep or Goat Users only**

Yes <input type="checkbox"/>  <input type="checkbox"/>	No <input type="checkbox"/>  <input type="checkbox"/>	1. Do you have a history of known valvular disease — heart murmurs — or congenital heart disease? If yes, date of diagnosis: Type of disease: Treatment: 2. Do you now have or have you had Q-fever?
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**Bat users only**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	1. Have you received the Rabies vaccine? If yes, dates of vaccination administration:  Have you ever had a Rabies titer? If yes, titer date and result: Please provide documentation of vaccine or titers to ASU Employee Health @ <a href="mailto:employeehealth@asu.edu">employeehealth@asu.edu</a>
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**4. Additional personal health concerns — all animal users**

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