

Medical Surveillance Questionnaire (Appendix C)

INSTRUCTIONS: Employees/Students/Volunteers working with research animals or entering a vivarium are required to complete this questionnaire to identify applicable health and safety recommendations. The purpose of the following questions is to determine if you have any special health needs to work safely with animals. Based on your answers, medical recommendations will be provided to reduce risk of undesirable health effects and may include wearing additional personal protective equipment or modifying work procedures. In some cases, further medical evaluation may be indicated at Altru Occupational Health (Employer Health Solutions). **This form will be reviewed by a health care professional and kept in your confidential medical record at Altru.**

Employee/Student Name: _____ UND ID#: _____

Male Female Other: Prefer not to answer

UND Department: _____ Job Title: _____

Local Address: _____ Phone: _____

Supervisor: _____ Species to be handled: _____

UND OCCUPATIONAL HEALTH QUESTIONNAIRE (Your PI/Supervisor should not see this page)

1. Have you received a Tetanus vaccine? Yes No Unsure
 - a. If yes, what is the date of your last Tetanus vaccination?
2. If you will be working with human blood/tissues/cells/cell lines in animals, have you received a Hepatitis B vaccination series? Yes No Unsure
 - a. If yes, please list vaccination dates: 1 2 3
 - b. List year of vaccination:
3. Have you completed a Hep-B titer test? Yes No
 - a. If yes, Titer result and date:

Do you have any of the following medical conditions?

Allergy and Respiratory System Health History

- | | YES | NO |
|--|--------------------------|--------------------------|
| • Asthma or other chronic respiratory disease | <input type="checkbox"/> | <input type="checkbox"/> |
| • Skin conditions (such as eczema, psoriasis, dermatitis) | <input type="checkbox"/> | <input type="checkbox"/> |
| • Allergic skin reactions (such as hives, rash, itching). If yes, please explain: | <input type="checkbox"/> | <input type="checkbox"/> |
| • Known or suspected animal allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Indicate any animal-related reaction(s): | | |
| <input type="checkbox"/> Runny/stuffy nose <input type="checkbox"/> Itching eyes <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing | | |
| <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest tightness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Hives | | |
| <input type="checkbox"/> Skin rash <input type="checkbox"/> Throat swelling <input type="checkbox"/> Other | | |
| • Known or suspected allergies to chemicals, latex, food, or environment. If yes, list: | <input type="checkbox"/> | <input type="checkbox"/> |

Medical Surveillance Questionnaire

Do you have any of the following medical conditions?

- If yes to any of the above conditions, list any treatments used to relieve your symptoms:

- Are you currently using respiratory protection or mask? If yes, list type:

- Have you been fit-tested? If yes, when was the last fitting:

Immune/Metabolic System Health History

- | | YES | NO |
|---|--------------------------|--------------------------|
| • Chronic health conditions such as diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| • Kidney or liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| • Valvular heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| • Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| • History of spleen problems or absence of spleen | <input type="checkbox"/> | <input type="checkbox"/> |
| • Pregnant or planning to become pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| • Immune system deficiencies or other limitations to your ability to fight off disease or infection (e.g., cancer, lupus, organ transplant, HIV infection, chronic infections) If yes, please list: | <input type="checkbox"/> | <input type="checkbox"/> |
| • Current medication or treatment that may suppress your immune system (e.g., high-dose steroids, prednisone, cancer therapy, radiation therapy) If yes, please list: | <input type="checkbox"/> | <input type="checkbox"/> |

Physical Health History

- | | YES | NO |
|--|--------------------------|--------------------------|
| • Vision or hearing problems | <input type="checkbox"/> | <input type="checkbox"/> |
| • Musculoskeletal disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| • Carpal tunnel syndrome or repetitive motion injury | <input type="checkbox"/> | <input type="checkbox"/> |
| • Chronic back or joint pain | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to any of the above physical concerns, please explain:

Do you have any health or workplace concerns not covered by this questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the Occupational Health staff or your primary care physician? **If yes, contact Altru Occupational Health (Employer Health Solutions) at 701.780.1947 to follow-up with this health assessment.**

By signature, I certify that the information provided is accurate to the best of my knowledge.

Participant Signature:

Date: