

**BATES COLLEGE  
LABORATORY ANIMAL OCCUPATIONAL HEALTH  
PROGRAM HEALTH QUESTIONNAIRE**

<i>Name (Last, First, M.I.)</i>		<i>College ID</i>	<i>Date of Birth</i>
<i>Home or College address</i>		<i>Home Phone</i>	<i>Date</i>
<i>Job Title</i>	<i>Work Phone</i>	<i>Email</i>	
<i>P/I Supervisor</i>		<i>Dept.</i>	<i>Temp Employee? Yes__ No__</i>

**INSTRUCTIONS:**

- 1) Fill in any missing personal information above
- 2) Complete Questionnaire Parts A, B,C. All complete sections are to be given to the Occ. Health Nurse or
- 3) Send all parts to: Central Maine Conditioning Clinic/Attn: Jen Messenger 30 Belgrade Ave. Auburn, Maine 04210; Phone 207-783-0018; Fax (207) 783-0019 Attn: Jen Messenger

**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  
 I am involved with veterinary care or animal husbandry  
 I am involved with research of animals or animal tissues

**Animals/Tissues/Body Fluids** (Check all that apply)

		<b>Frequency of Exposure</b>		
	<b>Daily</b>	<b>1 – 4 times/wk</b>	<b>1-3 times/ month</b>	<b>Infrequent 1-10 times/yr</b>
Rodents .....	<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"/>
Wild Rodents.....	<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"/>
Dogs .....	<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"/>
Birds .....	<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"/>
Other (list) .....	<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"/>

## HEALTH QUESTIONNAIRE

Name (Last, First, M.I)

Bates 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 (ie, toxic agents)	<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	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Pre-Exposure Rabies (series Of 3 & usually veterinarians or high risk individuals)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

#### II. ENVIRONMENTAL ALLERGIES ASTHMA

	yes	No	Don't know
1. Are you allergic to any animal(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If yes, list animals that cause your allergy symptoms _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any known allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what? _____			
List causes of allergies. _____			
4. List symptoms that occur when you are suffering your allergies _____			
5. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list cause(s) of asthma (if you do not know write unknown) _____			
6. Do you have allergy symptoms of asthma specifically related to animals that you currently work with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, have you seen by a physician for this?	<input type="checkbox"/>	<input type="checkbox"/>	
List symptoms: _____			
8. Do you experience shortness of breath at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you wear a fit tested respirator to perform any activities at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list date of last respirator fit testing _____			
Physician prescribing treatment: _____			

## HEALTH QUESTIONNAIRE (Continued)

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Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your health and would like to confidentially discuss with the Occupational Health Nurse?

Yes      No  
     

Please be informed that certain conditions can increase your potential risk of health problems when working with animals. These medical conditions could include but are not limited to allergies to animals and/or animal dander, asthma, heart valve disease, immunosuppression and chronic back injury. You should also be aware that animals kept at home could have an impact on your ability to perform certain care duties with selected species of animals. If you have pets or farm animals, be sure to inform your supervisor.

### Section C: Signature of Participant (Complete sections A,B,C)

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

Send completed and signed questionnaire to:

Central Maine Conditioning Clinic

30 Belgrade Ave

Auburn, Maine 04210

Fax: (207) 783-0019

Phone: (207) 783-0018