

PART B: PERSONAL HEALTH

	Yes	No	Don't Know	Year of Vaccination
➤ HAVE YOU BEEN IMMUNIZED?				
Tetanus Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B (series of 3 shots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rabies (series of 3 shots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

➤ INFECTION History (such as salmonella, shigellosis, hepatitis, tuberculosis):

	Yes	No	Don't Know
➤ DO YOU HAVE ANY ALLERGIES?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, cause of allergies: _____			
Symptoms of allergies: _____			
Treatments used to relieve your allergies: _____			

➤ DO YOU HAVE ASTHMA?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, cause of asthma: _____			
Do you have allergy symptoms or asthma specifically related to animals that you currently work with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, list symptoms: _____			
Do you experience shortness of breath at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, explain: _____			
Do you have any current skin problems related to work, (i.e. reactions to latex gloves, cracked/dry skin, rashes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, describe: _____			

➤ MEDICATIONS you are currently taking: _____

Are you currently under the care of a physician for any acute or chronic medical condition, such as blood pressure, kidney, heart, diabetes, or immunosuppression? yes no

If YES, list conditions: _____

Are there any health/workplace concerns not covered by this questionnaire that you would like to discuss with a physician? yes no

PART C: FOR INDIVIDUALS WORKING WITH NON-HUMAN PRIMATES ONLY

	Yes	No	Don't Know
• Have you ever had measles (rubeola)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Have you lived in countries other than the US? If YES, list countries: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Have you ever had <u>active</u> Tuberculosis (TB)? If YES, list year and TB treatment received: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Have you had a positive reaction to a TB skin test? If YES, date of last chest x-ray: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Have you ever received the TB vaccine Bacillus Calmette Guerin (BCG)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART D: FOR COMPARATIVE MEDICINE EMPLOYEES ONLY

- Mark if you use any of the following Personal Protective Equipment items (PPE) when working with animals: lab coat mask/respirator protective eye glasses
- Will you be required to lift animals, supplies or equipment exceeding 50 pounds?
 yes no don't know
- Are you or will you be engaged in a repetitive movement activity?
 yes no don't know

» Remember to sign, date and fax this form to USA Urgent Care at 251.414.8227.