

Medical Questionnaire for Students with Animal Contact

Student Information:

Name	<input type="text"/>	EWU ID #	<input type="text"/>
Email	<input type="text"/>	Phone	<input type="text"/>
Work Location (Building/Room)	<input type="text"/>		

Confidentiality:

All information on this form is confidential.

Bring this form to Providence Occupational Medicine (Providence), located in Spokane, for review by a physician. Providence will keep a record of this form in your medical file but will not share it with Eastern.

Eastern Washington University will NOT have access to the answers provided.

Form Instructions:

Please:

- Do not leave any question unanswered
- Provide an explanation for any question you answer YES to
- Ensure the completed form is legible
- EH&S recommends they use their eight (8) digit employee number and not your social security number
- Sign the completed questionnaire
- Place the questionnaire in the provided envelope, **seal the envelope**, and submit it to Providence.

Vaccinations may be recommended depending on the animals you will be exposed to and your vaccination history.

If you have questions about this form, please contact EH&S or the IACUC.

Providence Occupational Medicine Locations:

Downtown Spokane:

421 S. Division St, Suite 2, Spokane, WA 99202 **Phone:** 509-474-5858 **Fax:** 509-474-5859
Working Hours: Mon – Fri: 9 am – 5 pm

North Spokane:

551 E Hawthorne Rd. Spokane, WA 99218 **Phone:** 509-252-1905 **Fax:** 509-489-3874
Working Hours: Mon – Fri: 8:30 am – 5 pm

Spokane Valley:

1528 E. Desmet Court, Suite A1600, Spokane Valley, WA 99216 **Phone:** 509-944-8907 **Fax:** 509-944-8907
Working Hours: Mon – Fri: 9 am – 5 pm

Airway Heights:

11919 W. Sunset Highway, Suite D, Airway Heights, WA 99001 **Phone:** 509-474-2650 **Fax:** 509-508-4552
Working Hours: Mon – Fri: 8:30 am – 5 pm

Medical Questionnaire for Students with Animal Contact

To be completed by student:

Name

EWU ID # Email

Animal Research Species (select all that apply):

Mouse Rat Fish Insect* Other*

* List Species:

Anticipated frequency of animal contact:

To be completed by medical professional:

Student medical history has been reviewed by:

Recommendations about work with animals:

No Limitations

Limitations

Please explain any limitations:

Tetanus shot is up-to-date: Yes No

Need for follow-up medical evaluations: Yes No

If yes, please explain:

Medical Provider's Signature

Date

Allergy Symptoms:

Have you ever experienced any of the following allergy symptoms on a regular basis? (Please do not include symptoms experienced from a cold, flu, or other illness).

Symptoms	Year of onset	Present now	Spring	Summer	Fall	Winter	Not Seasonal	Home	Work	No difference
Watery or itchy eyes										
Runny or stuffy nose										
Sneezing spells										
Frequent cough										
Difficulty swallowing										
Excessive mucous										
Sinus problems										
Hives										
Swelling of lips or eyes										
Eczema										
Wheezing/chest tightness										

Medical History:

Have you had a tetanus booster in the past 10 years? Yes No

If yes, please specify the calendar year that your tetanus booster was received:

Have you had the Hepatitis B vaccine series? Yes No

If yes, please specify the calendar year that your vaccine series was received:

Do you have a chronic medical condition that requires medication? Yes No

Are you taking any medications that impair your immune system? Yes No

Do you have a valvular or congenital heart condition? Yes No

If you answered "yes" to any of the last 3 questions, please explain:

Atopic History:

Do you have allergies?

Yes

No

If yes, what are you allergic to?

If yes, what are your symptoms when your allergies act up?

Have you experienced allergic reactions at work or at school?

Yes

No

If yes, please indicate what were you allergic to?

Have you ever had Hay Fever?

Yes

No

If yes, how old were you when it first developed?

When was the last time you were troubled by hay fever? (Month/Year):

Do you have an allergy diagnosis from a physician?

Yes

No

Have you ever had a skin test for allergies (not TB)?

Yes

No

If yes, please indicate what were you allergic to?

Have you ever received allergy shots?

Yes

No

Have you ever taken medication for allergies?

Yes

No

If yes, what medications and how often do/did you take them?

Has a physician ever diagnosed you with asthma?

Yes

No

Have you had an attack of wheezing making you short of breath?

Yes

No

If yes, how old were you when you had your first attack?

Are you still occasionally troubled by these attacks?

Yes

No

Do you currently take medication for these attacks?

Yes

No

Are you allergic or sensitive to things that cause skin rashes?

Yes

No

If yes, what causes the rashes?

Is there anyone in your immediate family with allergies or asthma?

	Allergies	Asthma	Both	Neither	N/A
Father					
Mother					
Sister					
Brother					
Child					

Occupational History:

Have you ever used a respirator? Yes, required Yes, voluntary No

Have you ever worked with animals before? Yes No

If yes, please indicate which species and how many years you have worked with them.

Have you had allergic reactions to any of the animals that you have worked with? Yes No

If yes, indicate all species you were allergic to and when the allergies started (year or month & year)

For your current class or research project do you handle any of the following?

Live animals Yes No Unknown Animal carcasses Yes No Unknown

Live tissues Yes No Unknown Animal fluids Yes No Unknown

Animal cages Yes No Unknown

Do you work in the vivarium at least once a week? Yes No

If yes, how many days per week do you work with lab animals or their cages?

On those days, how many hours per day do you work with animals or their cages?

If no, over the past 6 months, during how many weeks have you had lab animal contact?

During those weeks, how many days per week have you worked with lab animals?

On those days, how many hours per day have you worked with lab animals?

How many hours per week do you usually have contact with the following species?

	Unknown	0 hours	<1 hr.	1-5 hrs.	6-10 hrs.	11-15 hrs.	16-20 hrs.	21+ hrs.
Mice								
Rats								
Fish								
Amphibians								
Insects								
Other								

When working with lab animals or their cages, how often do you do the following?

	Never	Less than ½ the time	Most of the time	Always
Wear gloves				
Wear a dust mask				
Wear other respirator				
Wear a gown or other protective clothes				
Wear a hair bonnet				
Wear shoe covers				
Wash hands after handling animals				
Wear eye protection				

Home Environment:

Have you ever had pets at home? Yes No

If yes:	Mark all animal(s) you have had in your home?	How long did you have the animal(s)?
Dogs		
Cats		
Other (specify)		

Are you, or were you, allergic to any of the above listed animals? Yes No



Do you have pets now?

Yes

No

Have you ever smoked cigarettes?

Yes

No

If yes, do you currently smoke cigarettes?

Yes

No

Do you have any questions you would like to speak to the medical provider about?

If you have questions for the medical provider:

When is the best time to contact you?

What is the best phone number for contact?

This form has been completed to the best of my knowledge.

Sign

Date

Please place your completed form in the envelope provided, seal the envelope and return it to Providence Occupational Medicine at the location of your choice (See page 1 of this document).