Animal Exposure Program Medical Questionnaire

Name: _____ UCF ID#_____ ☐Employee ☐Student ☐Volunteer

Address:_____ Phone:_____

Email:_____ Date of Birth: _____Cell Phone: _____

Supervisor/PI: _____ Department Name:_____ Date:_____

A. Immunization and Infectious Disease History

Have you ever had or do you now have any of the following immunizations? You must supply most recent year for immunization.

If the answer is yes, you must supply a date. If the answer is no, check the 'no' column. If the answer is unknown, select "Don't know".

Incomplete forms will be returned.

Vaccination History

	Yes	Date	No	Don't Know	Incomplete (Hep. B only)
Tetanus	☐	_____	☐	☐	
Hepatitis B (Series of 3)	☐	_____	☐	☐	☐

1. Will you be working with any biological materials? ☐ Yes ☐ No
   If yes, please explain:
   _____

2. Have you ever been diagnosed with an infectious, viral, bacterial, or parasitic illness that had been confirmed to have come from an animal? ☐ Yes ☐ No
   If yes, please explain:
   _____

3. Have you ever suspected that you have acquired an illness from an animal or animal materials/tissue at work or elsewhere, but were unable to confirm this? ☐ Yes ☐ No
   If yes, please explain:
   _____

B. Medical History

1. Have you been told by a physician that you have an immune compromising medical condition or are you taking medication that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)? ☐ Yes ☐ No
   If yes, please explain:
   _____

2. Have you been told by a physician that you have a chronic medical condition? ☐ Yes ☐ No
   If yes, please explain:
   _____

3. Are you currently taking any other medications? ☐ Yes ☐ No
   If yes, please explain:
   _____

C. Allergies/Asthma

1. Are you allergic to any animal(s)? ☐ Yes ☐ No

If yes, list the animals that caused your allergy symptoms: _____

2. Do you have any other known allergies? ☐ Yes ☐ No

If yes, please describe: _____

3. List symptoms that occur when you are suffering from your allergies.

☐ Sneezing ☐ Skin rash or hives ☐ Shortness of breath
☐ Watery or itchy eyes ☐ Runny or stuffy nose ☐ Other: _____
☐ Wheezing / Chest tightness ☐ Coughing

4. Does personal protective equipment alleviate these symptoms? ☐ Yes ☐ No

5. Have you ever been treated at a hospital, emergency room, urgent care or by paramedics for animal allergies? ☐ Yes ☐ No

6. List treatment that you receive to relieve your allergies: _____

7. Have you been treated for asthma? If yes, please list: ☐ Yes ☐ No

a. The cause(s) of your asthma: _____

b. Have you ever been hospitalized for asthma: _____

c. The number of asthma attacks per month: _____

d. The medications you take for your asthma: _____

8. Do you have skin problems related to work (e.g. reactions to latex gloves, dry/cracked skin, rashes)? ☐ Yes ☐ No

If yes, please describe: _____

9. Do you experience shortness of breath at work? ☐ Yes ☐ No

If yes, please explain: _____

10. Is there a family history of hay fever, asthmas, skin problems, or eczema? ☐ Yes ☐ No

If yes, please explain: _____

11. Outside of work, do you have any exposure to animals? ☐ Yes ☐ No

If yes, please explain: _____

D. Pregnancy

1. Are you pregnant, suspect you are pregnant or contemplating pregnancy? ☐ Yes ☐ No

2. Do you have work related questions concerning pregnancy that you would like to discuss with an Occupational Medicine Physician? ☐ Yes ☐ No

If yes, please explain: _____

E. Additional Questions and Concerns

1. Do you wish to talk to a medical provider concerning laboratory/client animals, hazards, or this questionnaire? ☐ Yes ☐ No

I have answered the questions on this form truthfully and to the best of my knowledge.

Enrollee Name (print) _____

_____ Date: _____

Enrollee Signature