# University of Pittsburgh Animal Exposure Surveillance Program (AESP)
# Initial Health Questionnaire 2024

## Instructions for Enrollment

1. Complete this Animal Exposure Surveillance Program Health Questionnaire and Submit via **one** of the following below:

    1. **FAX:** 412-647-5051
    2. **Deliver:** *My*Health@Work for the University of Pittsburgh- Employee Health Services Clinic, 3708 Fifth Avenue, **Medical Arts Building, Suite 505**, Pittsburgh, PA 15213 between 7:00 a.m. and 3:30 p.m. Monday through Friday.
    3. **TEAMS Link –** https://www.ehs.pitt.edu/lab-safety/animal-research

2. **Do NOT send the completed form via campus mail.**
3. **Do NOT send the completed form to your supervisor.**
4. **Do NOT send the completed form to the Department of Environmental Health and Safety.**
5. **Do NOT send photos of completed form (scans only).**
6. **Do NOT put a campus address on form.**
7. **Please complete entire form.**

**Email of this form will not be accepted**

All information collected by this University of Pittsburgh program will be handled with the strictest confidence and in compliance with all applicable regulations. Your personal and medical information will only be available to those clinical care providers in Employee Health Services with a need to know.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employer and other entities covered by GINA Title II from requesting genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individuals’ family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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## Demographics

**Name:** _____ **Date:** _____

***Required**
**Date of Birth:** _____ **Pitt 2P#:** **2P** _____

**Work Status (circle all that apply):** Employee Student Visitor
Other: _____ **Job Position:** _____

**Department - BSL1, BSL2, BSL3, DLAR, RBL** _____

***Required**
**Home Address:** _____ **Work Email:** _____

**City/State/Zip:** _____

**Cell Phone:** **Supervisor/PI:** _____

## Occupational Review

**What are your job duties?** _____

***Please indicate all species of animals that you will be* working *with or will be listed on a protocol for:***

| **Check all that apply** | **Yes** | **No** | ***Check all that apply*** | **Yes** | **No** |
|---|---|---|---|---|---|
| Rodents | | | Macaques--Rhesus, Cynomolgus | | |
| Mice/Rats/Hamsters/ Gerbils/Guinea Pigs **(Circle)** | | | Baboons | | |
| Prairie Dogs | | | Farm Animals | | |
| Rabbits | | | Sheep/Goats/Swine **(Circle)** | | |
| Ferrets | | | Dogs | | |
| Fish/Frogs/Turtles **(Circle)** | | | Cats | | |
| Non-Human Primates | | | Tissue Handler: Human/Animal **(Circle)** | | |
| New world monkeys--squirrel monkeys | | | Other: | | |
| I will not be working with animals or human/animal tissue, but this form is required for my lab's protocol. | | | | | |

## TB Review

Date of last TB Skin/QuantiFERON Test: Month:_____ Year:_____

Have you ever had a positive TB screening? **Yes** **No**

If YES: Were you treated with medication? **Yes** **No**

Date of last chest X-Ray (if prior positive TB test)? Month:____ Year:_____

**Infectious Disease Review**

**Please indicate if you have a history of an immunization (I), have worked with in the past (P), or will work with (W) any of the following?**

| Check all that apply | I | P | W | Check all that apply | I | P | W |
|---|---|---|---|---|---|---|---|
| Anthrax | | | | HIV | NA | | |
| Avian Flu | NA | | | Influenza Viruses | | | |
| Botulinum | | | | Human Retroviruses | NA | | |
| Brucella | NA | | | Japanese Encephalitis | | | |
| Burkholderia Mallei | NA | | | Malaria | NA | | |
| Burkholderia Pseudomallei (Meliodisis) | NA | | | Orthopox viruses (Monkey pox) | | | |
| Chikungunya | NA | | | Rift Valley Fever Virus | NA | | |
| Dengue | NA | | | SARS | NA | | |
| Eastern Equine Encephalitis | NA | | | Toxoplasma Gondi | NA | | |
| Francisella Tularemia | NA | | | Vaccinia | | | |
| Hepatitis A | | | | West Nile Virus | NA | | |
| Hepatitis B | | | | Yellow Fever Virus | | | |
| Hepatitis C | NA | | | Yersinia Pestis (Plague) | NA | | |
| Rabies | | | | Other: | | | |

**General Occupational Review**

What type of PPE have you used in the past?

_____

_____

**Do you have prior history of working with animals?** **Yes** **No**

When? Month/Year: to Month/Year:

If YES: Which species did you work with?

_____

**Medical History**

Please list any history of any immunocompromised conditions (Lupus, Cancer, Organ Transplant, Oral Steroids, etc)

_____

Please list any chronic health conditions (Diabetes, heart disease, cancer, liver disease, etc)

_____

Please list any chronic skin conditions Eczema/Urticarial/Hives/Skin Disease

_____

Please list any chronic Respiratory Diseases (Asthma, COPD, etc)

_____

Please list any medications used to treat respiratory conditions

_____

**Do you now, or have you ever taken any asthma related medications?** **Yes** **No**

If YES: Which medications and how often? _____

_____

**Do you have prior history of allergic symptoms with animal exposures? If so, to what animal(s)?** _____ **Yes** **No**

**If YES:** Which of the following symptoms, have you experienced:

| | | |
|---|---|---|
| Chest tightness or wheezing | **Yes** | **No** |
| Coughing | **Yes** | **No** |
| Itching/Tearing/Swelling of Eyes | **Yes** | **No** |
| Nasal Discharge/Stuffiness | **Yes** | **No** |
| Sneezing | **Yes** | **No** |

Please list any medications to control animal exposure /allergy symptoms:

_____

_____

If YES: Was the medication effective in controlling your symptoms? **Yes** **No**

If YES: Have you used any protective equipment (mask, gloves, etc.) to control allergy exposure/symptoms? **Yes** **No**

If YES: Was the protective equipment effective in controlling your symptoms? _____ **Yes** **No**

**Do you have or have you ever had a history to Anaphylaxis?** **Yes** **No**

**If YES to Anaphylaxis, what was the cause?** _____

Have you ever had any allergy testing completed? **Yes** **No**

If yes to having any allergy testing completed, when? _____

**If yes to having any allergy testing completed, what were the results?** _____

**Have you ever taken any allergy injections?** **Yes** **No**

If YES: When, and were they effective? _____

**Have you ever had a severe reaction to latex devices or products?** **Yes** **No**

If YES: Under what circumstances did it occur? _____

_____

_____

**After handling latex products, have you ever experienced any of the following:**

Difficulty breathing **Yes** **No**

Chapped or "cracking" of hands **Yes** **No**

Itching, redness and/or swelling (hands, eyes) **Yes** **No**

Hives **Yes** **No**

Have you ever been tested for a Latex Allergy?

If YES to being tested for a Latex Allery, what were the results? **Yes** **No**

_____

**General History**

**Do you have animals at home?** **Yes** **No**

If YES: Which kind of animal? _____

**Have you traveled outside the US within the last year?** **Yes** **No**

If YES: To which country/countries? _____

If YES: Have you had any health issues since returning? _____

**Have you received a Tetanus Booster in the past 10 years?** **Yes** **No**

When? _____

**Do you have any other health problems?** **Yes** **No**

If YES: Please list:

_____

_____

_____

_____

_____

_____

**Are you taking any other medications?** **Yes** **No**

If YES: Please list:

_____

_____

_____

_____

_____

**I certify that I fully understand all request for information contained on this form and I certify that the information supplied by me on this form is complete and correct to the best of my knowledge.**

**Signature:** **Date:**

***My*Health@Work *STAFF* ONLY**

**I have reviewed the information provided.**

**Signature:** _____ **Date:** _____

Are you an employee of ***BOTH*** PITT (The University of Pittsburgh) and UPMC (University of Pittsburgh Medical Centers)?

**Yes or No**

**If Yes -**

I hereby consent to my UPMC employee health information being accessed by University of Pittsburgh employee clinic staff for the purpose of occupational health or delivery clinical care and/or to confirm my vaccination/lab work status as an employee.

**I agree or I disagree**

**Signature:** _____ **Date:** _____