

Memo

To:

From: Marjorie Spence, ARNP/Gale Hockman

Date: 1-1-2012

Re: Significant Biological Agent or Animal Contact Health Surveillance Questionnaire

1. Please complete the annual medical survey attached. The questionnaire will be placed in your Employee Health Record. This information is required under VHA Program Guide 1200.7 (Research and Development Occupational Health and Safety for Veterinary Medical Units Program Guide).
2. Please page Marjorie Spence on VA# 1820 or ext. 5183 if you have any questions about the forms. Please send the completed forms to **Employee Health at mail 11C**, as soon as possible. You will be contacted if any of your immunizations need to be updated. Thank you for your timely support of this program.

Marjorie Spence ARNP
Gale Hockman
Occupational Health Nurse

CONFIDENTIAL MEDICAL INFORMATION

**SIGNIFICANT BIOLOGICAL AGENT OR ANIMAL CONTACT
HEALTH SURVEILLANCE QUESTIONNAIRE**

Date: _____

SS#: _____

Service: _____

Email address: _____

Principal Investigator/Supervisor: _____

Name: _____ Birth Date: _____

Previous Evaluation at Employee Health? Yes No

Status (Check all that apply):

UF Faculty

VA Staff

Student

Animal Handler

Veterinarian

Research Technician

Other _____

1. What species of animals or types of biological agents will you be handling?

2. How often (never, rarely, sometimes, always) do you wear disposable gloves, a gown, a mask, a cap, or protective eyewear as part of assigned duties?

3. Do you smoke, eat, or drink in animal holding areas or procedure areas?

4. Do you work with chemicals in the workplace and have you had any symptoms associated with working with these chemicals?

5. MEDICAL HISTORY

Do you have any ongoing medical problems? If yes, explain.

6. Have you had (check all that apply):

- | | | |
|------------------------------------|------------------------------------|---|
| Pneumonia | Recurrent Bronchitis | Tuberculosis |
| Heart Disease | Rheumatic Fever | Heart Murmur & Valve Disease |
| Diabetes | Kidney Disease | Liver Disease |
| Cancer | Gastrointestinal Disorder | Loss of Consciousness |
| Seizures | Arthritis | Chronic Back or Joint Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Allergic Skin Problems |
| <input type="checkbox"/> Sinusitis | | <input type="checkbox"/> Eczmea |

If yes, please explain.

7. Are you currently pregnant, contemplating becoming pregnant within the next year?

Yes No

**I prefer not to answer this question for personal privacy reasons and hereby assume personal responsibilities for any adverse consequences attendant to failure to provide this information. (Please sign):*

* _____
signature

* _____
date

8. Have you been told by a physician that you have an immune compromising medical condition or are taking medications that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)?

Yes No

If Yes, Please list medications.

9. Drug Allergies:

Are you allergic to?

Dog	Primates	Alfalfa	Goats	Other:
Hog	Guinea Pigs	Latex	Birds (feathers)	
Rat or Mouse	Cattle	Weeds	Sheep (wool)	
Cat	Rabbits	Grasses	Trees	

10. If any allergic symptoms occur during or after contact with a laboratory animal species (sneezing spells, runny or stuffy nose, watery or "itchy" eyes, coughing, wheezing, or shortness of breath, skin rashes or hives, difficulty breathing), and if so, which species is involved, and how frequently does each symptom occur (never, monthly, weekly, daily).

11. Current Prescribed Medications Taken on a Regular Basis:

12. Systemic Illnesses (i.e., diabetes, chronic bronchitis, cancer, etc.):

13. Briefly describe what type of contact you have with lab animals (i.e., clean out cages, do organ biopsies on frogs, etc.). PLEASE be sure to state how frequently you work with the animals (i.e., daily, weekly, etc.)

<u>Type of Contact</u>	<u>Frequency</u>
_____	_____
_____	_____
_____	_____

signature

date

RECORD OF IMMUNIZATION

Indicate the date of most recent vaccination (or blood test to document immunity). Mark "?" if you do not recall the date. Mark "ND" (for never done) if test or vaccination has never been done.

Measles _____	Hepatitis A _____	CMV _____
Mumps _____	Hepatitis B _____	"Q" Fever _____
Rubella _____	Rabies _____	BCG _____
Vaccinia (smallpox) _____		
Yellow Fever _____		
Toxoplasmosis _____		

** Date of last tetanus booster: _____
Date of last rabies vaccine (if applicable): _____
Date of last rabies titer (if applicable): _____

Tuberculosis Skin Testing

** Date of last PPD skin test: _____ Positive, Negative
If POSITIVE, date of last Chest X-Ray: _____
If POSITIVE in the past, are you having any of the following symptoms (check box)?:

Fever	Chronic Cough	Bloody Sputum
Weight Loss	Shortness of Breath	

Have you ever contracted a disease from animals, or experienced an animal related injury (including bites, scratches, needlesticks, etc)? If yes, please explain below:

Do you work with species of, or biological material from, non-human primates?

Yes No

Are you involved with recombinant DNA technology? Yes No. If yes, does the research involve techniques in which viable, recombinant DNA-containing micro-organisms are used to infect animals that then require Biosafety Level 3 containment? Yes No

Date of Last Rabies Vaccine (if applicable): _____

EMPLOYEE CONTACT INFORMATION

INSTRUCTIONS: PLEASE COMPLETE THIS FORM. THE FOLLOWING INFORMATION IS REQUESTED TO FACILITATE CONTACTING YOU ABOUT MATTERS RELATED TO YOUR VISIT, INCLUDING TEST RESULTS AND FOLLOW-UP APPOINTMENTS. THANK YOU.

EMPLOYEE NAME: (Last, First, Middle) _____

FULL SSN: _____ DOB: _____

HOME ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____ WORK PHONE: (____) _____

SEX (CIRCLE ONE): MALE FEMALE RELIGIOUS PREFERENCE: _____

MARITAL STATUS (CIRCLE ONE): NEVER MARRIED SEPARATED MARRIED DIVORCED WIDOWED

POSITION TITLE: _____ NF/SG VHS SERVICE _____ EXT _____

PLACE OF BIRTH: CITY _____ STATE _____

NEXT OF KIN: (Last, First): _____ Phone (____) _____

RELATIONSHIP (CIRCLE ONE): SPOUSE, CHILD, PARENT, RELATIVE, OTHER, SIGNIFICANT OTHER

ADDRESS OF NOK: _____ CITY _____ STATE _____

EMPLOYER: _____ ADDRESS: _____

CITY: _____ STATE: _____ PHONE: (____) _____ OCCUPATION: _____

FATHER'S NAME (Last, First): _____ LIST EVEN IF DECEASED

MOTHER'S NAME (Last, First): _____ MOTHER'S MAIDEN NAME: _____

HAVE YOU EVER RECEIVED CARE AT ANY VA? _____

MOST RECENT VA FACILITY LAST SEEN (NAME, CITY, STATE): _____

ARE YOU A VETERAN? _____ IF YOU ARE A VETERAN, PLEASE PROVIDE A COPY OF YOUR DD-214 TO REGISTER AS A VETERAN

THE OFFICE OF THE SURGEON GENERAL REQUESTED THAT THE VA COLLECT RACE AND ETHNICITY INFORMATION FROM ALL OF OUR PATIENTS. PLEASE CHECK THE BOXES THAT APPLY TO YOU.

ETHNICITY: (Check one) _____ SPANISH, HISPANIC OR LATINO _____ NO, NOT SPANISH, HISPANIC OR LATINO

RACE: (Check one or more) _____ AMERICAN INDIAN OR ALASKA NATIVE _____ ASIAN _____ DECLINED
_____ BLACK OR AFRICAN AMERICAN _____ WHITE _____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

Privacy Act Information: The VA is asking you to provide the information on this form under Title 38, United States Code sections 1710, 1712 and 1722. The information is collected at the request of the Surgeon General and will help us track diseases that are more common in certain races and ethnicities. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status and personnel administration. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you give VA your Social Security Number, VA will use it to administer your VA benefits, to identify veterans and persons claiming or receiving VA benefits and their records and other purposes authorized or required by law.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS ON WHO CAN SIGN ON BEHALF OF THE VETERAN OR PATIENT.

SIGNATURE OF APPLICANT: _____ DATE: _____