## ENVIRONMENTAL HEALTH & SAFETY | OCCUPATIONAL HEALTH

## INITIAL MEDICAL SURVEILLANCE QUESTIONNAIRE

Fill out the attached medical surveillance questionnaire. The personal healt University of Colorado, Denver in this questionnaire is used by the Departm Occupational Health Program's clinicians to establish a baseline medical his Submission of this Initial Form as well as Annual Renewals is an Institution	nent of Environmental Health tory. <u>All information is privil</u> e	and Safety's (EHS) eged and confidential.
SUBMISSION INSTRUCTIONS: This form can be emailed, mailed or submitt	ed in person THE PREERRE	D METHOD IS ELECTRONIC
·	•	
ADDRESS: Occupational Health Program, Mail Stop H275, 12348 East Mont		Colorado 80045
	X: 303-724-9213	
Section 1.0 PERSONAL INFORMATION		
Name: Female Male Date of Birth:	Today's Date:	Speed Type:
Emp or Student ID #: Job Title:	PI/Supervisor:	
Campus: AMC Downtown VA DH Boulder CSU Other:	Dept:	
Work #: Cell #: Building and Lab Room #:	<u> </u>	
I am part of an IACUC or IBC Protocol: Yes No Unknown IAC	UC IBC Email:	
•	2 weeks 3 - 24 months	> 2 years
Preferred language: Would you like an interpreter?	Yes No	•
Section 2.0 OCCUPATIONAL DUTIES and LABORATORY EXPOSURE		
Check the boxes below to describe your handling of human cells, tissue, blo	od.	
Human or Animal cells / Tissue culture <u>ONLY</u>		
Human cells, cell lines, blood or tissue		
Unfixed animal tissue		
i.e. Harvesting organs, tissues, cells, etc. (directly from animals prior to	fixative agent)	
Animal Cell Culture	madive agency	
Non-Human primate (monkey) tissue (i.e. Macaque, Cebus, etc)		
None of the ABOVE <b>Other</b> - Describe:		
Briefly describe daily duties/job requirements with Cells/Tissue Culture:		
bheny describe daily daties/job requirements with early hisae earthref.		
7. Are you or will you be using any agent from the following hazardous grou	ps? (Check all that apply)	
Recombinant DNA (rDNA): Animal Viral Bacterial Human Oth	er: Describe	:
Infectious Agents (i.e. HIV, E. Coli, Dengue, West Nile Virus, etc) Pleas	e list:	
Viral Vectors Please list:		
Radioactive Material Describe:		
Formaldehyde: $<10\%$ $>=10\%$		
Where do you work? AIP 3rd floor Pathology Research Histology	ogy Shared Resource Group	RC1N Teaching Lab
Other:		
Anesthetic gases Describe:		
Teratogens/Carcinogens Please list:		
Nanoparticles Describe:		
Lasers: Microscopy Class 3B Class 4 Anti-neoplastic drugs Please list:		
Toxins/Venoms Please list:		
Others:		
NO HAZARDOUS GROUPS		
8. Select the following person protective equipment (PPE) used in your	Protective eye glasses	Yes No
lab / work area.	Mask/Respirator	Yes No
ido / Horit di cui	Lab Coat	Yes No
	Gloves	Yes No
9. Are you or will you be working with any needles or sharps?	Yes No	

## OCCUPATIONAL LABORATORY ANIMAL HISTORY

The purpose of this section is to determine if you have work-related activities that may predispose you to acquiring work related allergic and autoimmune responses while working with research animals.

1. Do you work with **live** animals?

2. Do you work with whole animal cadavers?

Yes No Yes No

3. Will animals be present in your work area?

Yes No

## If **NO** to **all 3 questions above**, skip to Section 4.0

If <b>YES</b> to <u>any</u> of the 3 q	uestic	ns abov	<b>≀e</b> ,cont	inue to <u>Sec</u>	tion 3.	<u>0</u> (comp	olete the	entire for	m).
Section 3.0 OCCUPATIONAL LAB	ORATO	RY ANIMAI	L HISTOF	RY					
1. I have worked with laboratory anin	nals in th	e nast.		Yes	No				
a. How many months/years did you			rv animak	2 Months	Years	Types of	animals:		
2. I perform animal handling or proce				Yes	No				
Check the boxes below to describe yo									
Animal Species		<u></u>		<u>.                                    </u>					
Fish/Frogs (other aquatics)									
Rodents (mice, rats)									
Hamsters, Gerbils, Guinea Pigs, Chino	hillas								
Rabbits									
Cats									
Pigs: Awake Anesthe	tized O	nlv							
Sheep/Cows		-							
Field Work:									
(Where and what animals?)									
,									
Other Animal:									
Describe daily duties/job requirements	s with Ar	imals:							
4. Do you have animals at home?	Yes	No							
•	163	NO							
Please list the animals:									
<ol><li>Do you think you are allergic to any</li></ol>	/ animals	? Yes	No	If <b>no</b> , go to qu	estion 6.	•			
Please list the animals:									
Do you have any of the following	ng types								
Reaction		Curr	ent Reac	tion (in last 1		:hs)		Prior Reac	tion
a. Runny/Stuffy Nose			Yes	N	lo		Yes	Date:	
b. Itchy/Reddened Eyes			Yes		lo		Yes	Date:	
c. Cough			Yes	N	lo		Yes	Date:	
d. Wheezing			Yes	N	lo		Yes	Date:	
e. Chest Tightness			Yes	N	lo		Yes	Date:	
f. Shortness of Breath			Yes	N	lo		Yes	Date:	
g. Hives/Skin Rash			Yes	N	lo		Yes	Date:	
h. Throat Swelling/Difficulty Swall	owing		Yes	N	lo		Yes	Date:	
i. Difficulty Breathing			Yes	N	lo		Yes	Date:	
6. Have you ever experienced an anima	l-related	injury (inclu	ding bites,	scratches or inj	uries invo	olving cage	s or equipme	nt) or contra	cted a
disease or infection from animals?	Yes	No		-				•	
Please explain:									
Section 4.0 Medical History									
1. Have you ever been diagnosed and	l/or treat	ed for the f	following (	diseases/condit	ions? ( <b>c</b> h	eck all th	nat apply)		
Emphysema		ular Heart E		Please describ				s medicatio	ns etc
Chronic Bronchitis/Pneumonia		of Consciou		for all items cl			•	is, medicado	113, CC
Heart Murmur/Valve Disease		tness of Bre			ICCNEU II	1 1113 3500	011.		
Seizures	Canc			-					
Diabetes		Blood Press	CUITO	1					
		IE OF THE		-					
Epilepsy	NUN	E UT I TE	ADUVE	4					
Other:				İ					

2. Have you ever	Yes		No						
a. If "YES", what are you allergic to?									
3. Do you have a	Yes		No						
4. Have you ever been skin tested for allergies?					Yes		No		
	a. If "YES", what substances were you found to be allergic or sensitized to?								
NONE	Ragweed	Grass	Trees	Mold	,	*****			
Mice/Rats	Dust	Cats	Dogs	Other:					
5. Have you ever				herapy) shots?	Yes		No		
a. If "YES", w	hat year did you	received the	shots?						
6. Do you have v	vork-related / jo	b-specific trave	el plans to a f	foreign country	within the next	year? Yes	No V	Vhere?	
7. Have you ever					No	,	1		
a. What was t	the Spirometry for	or?			•	D	ate of S	pirometry:	
8. Has a doctor e				es No		•		,	
	hat year did you								
	rrently taking mo		er over-the-c	ounter or	Yes		No		
	n) to control you						110		
	he triggers for ye ever hospitalized		Yes	No Date(s):					
•	•				NI.				
<ol><li>Are you curre Please descr</li></ol>		K restrictions c	or ilmited duty	y? <b>Yes</b>	No				
10. Do any of the	following apply	to vou?	Yes	No					
=		=			HIV//AIDS leuk	emia lymnho	oma or	most other cancers;	
	e any conditions splant; or primar				MIV/AIDS, ICUM	allia, iyinpik	Jilia, Oi	וווטאני טעוובו במווכבוא,	
_		-	=		akan tha immu	ac cyctam?			
	e a severe autoi		-	-		-			
							teroids	(e.g. prednisone),	
		some medicines for autoimmune disease, or medicines taken after an organ transplant?							
d. Are you now taking cancer treatment with drugs or radiation or have you taken such treatment in the past 3 months?								. =	
d. Are you nov	v taking cancer	treatment with	drugs or rac				the pas	t 3 months?	
11. List any medic	ations or treatm	nents you are c	currently takir	diation or have y	ou taken such	reatment in	immu	nosuppression	
11. List any medic	_	nents you are c	currently takir dication) or a	diation or have ying or have taken	ou taken such	reatment in	immu asthma	nosuppression a medications:	
11. List any medic	ations or treatm motherapy, and	nents you are c	currently takir dication) or a	diation or have y	ou taken such	reatment in r that cause or allergy/	immu asthma	nosuppression	
11. List any medic (steroids, cher	ations or treatm motherapy, and	nents you are o transplant med	currently takir dication) or a	diation or have ying or have taken	ou taken such on in the last year medications,	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher	ations or treatm motherapy, and	nents you are o transplant med	currently takir dication) or a	diation or have ying or have taken	ou taken such on in the last year medications,	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher	ations or treatm motherapy, and	nents you are o transplant med	currently takir dication) or a	diation or have ying or have taken	ou taken such on in the last year medications,	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me	cations or treatm motherapy, and edication	nents you are c transplant med <b>Dose</b>	currently takir dication) or a <b>F</b>	diation or have ying or have taken	ou taken such on in the last year medications,	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me	edication  dical History -	nents you are c transplant med <b>Dose</b>	currently takir dication) or a <b>F</b>	diation or have ying or have taken	ou taken such in the last yea medications,  Last take	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me Section 4.1 Med Tetanus vaccine	edication  dical History -	nents you are contransplant med Dose	currently takin dication) or a F	diation or have y ng or have taken ny <b>heart/lung</b> requency	ou taken such on in the last year medications,	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me Section 4.1 Med Tetanus vaccine Hepatitis B series:	dical History -  (Td/ Tdap):  #1:	nents you are of transplant med Dose  Immunication #2:	currently taking dication) or a Figure Figur	diation or have y ng or have taken ny heart/lung requency  or titer:	ou taken such in the last yea medications,  Last take	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me Section 4.1 Med Tetanus vaccine Hepatitis B series Rabies vaccine s	dical History - (Td/ Tdap):  #1:  shot, enes: #1:	nents you are of transplant med Dose  Immuniratio  #2: #2:	currently taking dication) or a Figure Figur	or titer:	ou taken such in the last yea medications,  Last take  Other:	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me Section 4.1 Med Tetanus vaccine Hepatitis B series:	dical History - (Td/ Tdap):  #1:  shot, enes: #1:	nents you are of transplant med Dose  Immuniratio  #2: #2:	currently taking dication) or a Figure Figur	or titer:	ou taken such in the last yea medications,  Last take  Other:	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me Section 4.1 Med Tetanus vaccine Hepatitis B series: Rabies vaccine s Immunization	dical History - (Td/ Tdap): #1: shot, eries: #1:  Records mus	Dose  Immuniratio  #2: #2: st be brougl	currently taking dication) or a Final Fina	or titer:	ou taken such to the last year medications,  Last take  Other:	reatment in r that cause or allergy/	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me Section 4.1 Med Tetanus vaccine Hepatitis B 3 shots: Rabies vaccine 3 Immunization Section 4.2 Me	dical History - (Td/ Tdap): #1: Shot: #1: Records must	Dose  Immuniratio  #2: #2: st be brough	currently taking dication) or a Final Fina	or titer: appointment	ou taken such to in the last year medications,  Last take  Other:	r that <b>cause</b> or <b>allergy/</b>	immu asthma	nosuppression a medications:	
11. List any medic (steroids, cher Name of Me  Section 4.1 Mec  Tetanus vaccine Hepatitis B series: Rabies vaccine 3 Immunization  Section 4.2 Me  1. Date of last PF	dical History - (Td/ Tdap):  #1:  shots: #1:  Records must  dical History - D skin test or IC	Immuniratio #2: #2: st be brough Tuberculosis GRA Blood Test	pons  #3: #3: #4:  Screening it:	or titer: appointment	ou taken such to in the last year medications,  Last take  Other:	r that cause or allergy/	e immu asthma Reas	nosuppression a medications: son for Taking	
11. List any medic (steroids, cher Name of Me Name of Me Section 4.1 Mec Tetanus vaccine Hepatitis B series: Rabies vaccine 3 Immunization Section 4.2 Me 1. Date of last PF a. If positive, d	dical History -  (Td/ Tdap):  #1:  **Records mustical History -  D skin test or IC  ate of last chest	Immuniratio #2: #2: st be brough Tuberculosis GRA Blood Test : x-ray?	#3: #3: #4: Sereening it: Result:	or titer: appointment  Result: Positive	ou taken such to in the last year medications,  Last take  Other:  Positive  Negation	r that cause or allergy/n	e immu asthma Reas	nosuppression a medications: son for Taking  thest x-ray done	
11. List any medic (steroids, cher Name of Me Name of Me Section 4.1 Med Tetanus vaccine Hepatitis B series: Rabies vaccine stables vaccine stables vaccine stables vaccine 1. Date of last PF a. If positive, db. Did you rece	dical History -  (Td/ Tdap):  #1:  **Records mustical History -  D skin test or IC  ate of last chest  existing a series of the street of the	Immuniratio  #2: #2: st be brougl  Tuberculosis GRA Blood Test : x-ray? Gold or TSPOT	#3: #3: #4 to your  Sereening  It:  Result:  T (IGRA confil	or titer: appointment  Result: Positive	ou taken such to in the last year medications,  Last take  Other:  Positive  Negation	r that cause or allergy/n	e immu asthma Reas	nosuppression a medications: son for Taking	
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11. List any medic (steroids, cher Name of Me Name Name Name Name Name Name Name Nam	dical History - (Td/ Tdap): #1: #1: #1: #1: #1: #1: #1: #1: #1: #1	ments you are of transplant med Dose  Immuniratio  #2: #2: #2: st be brough  Tuberculosis GRA Blood Test: x-ray? Gold or TSPOT Negative Funtry (with a hinguerin (BCG) v FOR WOMEN  Inning to be pre- /materials th	#3: #3: #3: #4: Result: T (IGRA confinence vaccine as a contion of the continuous of the continuous of the continuous of the contion of the continuous of the continu	or titer: or titer: appointment  Result: Positive rmation) for a p of Tuberculosis child?	Other:  Other:  Ositive  Negative  Negative  Ositive PPD test  Yes  Yes  Yes  Outs to work w	reatment in r that cause or allergy/n  Negative //e ? No	No C Ye	chest x-ray done es Date:	

Section 5.0 Respiratory Screening		
1. Have you been fitted for a respiratory protection device?	? Yes No	
<ul><li>a. If YES, what kind and when:</li></ul>		
N-95	Date:	
½ Face, Negative Pressure Respirator	Date:	
Full-Face Negative Pressure Respirator	Date:	
Self-Contained Breathing Apparatus (SCBA)	Date:	
Conclusion		
Do you have any concerns or questions about occupational Please elaborate:	health and safety that is related to your job	o? Yes No
Consent for Clinical Services		
I hereby authorize the health care professionals employed of Campus to provide education and counseling, recommend a from the clinical appointment. This authorization includes plab work, and/or provide immunizations and clinical services	appropriate evaluation and follow-up, and moermission to review my immunization and n	aintain medical records created nedical history, to obtain routine
Employee/Applicant Signature:		
(If unable to submit, check form	for all red highlighted fields and verify these	e have been completed.)
FOR C	LINIC USE ONLY	
Provider Notes:  Enrollment completed:		Oate:
Enrollment <b>not</b> completed, pending:		
	Hamadaya ayaya adyaabiaa x	
Education and Counseling on Animal Allergies Counseled on injury/first aid/animal bites/scratch procedures  Reproductive Health Hazards Counseling given	Hazardous group education provided Health Counseling Referred for identified hazardous group Recommend Fit Tecting	EHSA s