



ENVIRONMENTAL HEALTH & SAFETY | OCCUPATIONAL HEALTH

INITIAL MEDICAL SURVEILLANCE QUESTIONNAIRE

Fill out the attached medical surveillance questionnaire. The personal health and medical information provided by employees of University of Colorado, Denver in this questionnaire is used by the Department of Environmental Health and Safety's (EHS) Occupational Health Program's clinicians to establish a baseline medical history. All information is privileged and confidential. Submission of this Initial Form as well as Annual Renewals is an Institutional requirement for entering research areas.

**SUBMISSION INSTRUCTIONS:** This form can be emailed, mailed or submitted in person. **THE PREFERRED METHOD IS ELECTRONIC.**  
**ADDRESS:** Occupational Health Program, Mail Stop H275, 12348 East Montview Blvd., 2<sup>nd</sup> Floor, Aurora, Colorado 80045  
**EMAIL:** [Occupational.Health@ucdenver.edu](mailto:Occupational.Health@ucdenver.edu) **PHONE:** 303-724-9145 **FAX:** 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:  |
| Work #:                                | Cell #:   | Building and Lab Room #:       |             |                |               |             |
| I am part of an IACUC or IBC Protocol: |           | Yes                            | No          | Unknown        | IACUC         | IBC         |
| Employment Status:                     | Full time | Temp/Intern:                   | Summer only | 2 - 12 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, blood.

Human or Animal cells / Tissue culture ONLY

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

Non-Human primate (monkey) tissue (i.e. Macaque, Cebus, etc)

None of the ABOVE **Other** - Describe:

Briefly describe daily duties/job requirements with Cells/Tissue Culture:

7. Are you or will you be using any agent from the following hazardous groups? (**Check all that apply**)

|  |                         |           |  |       |                   |           |
|--|-------------------------|-----------|--|-------|-------------------|-----------|
| Recombinant DNA (rDNA):  | Animal                  | Viral     | Bacterial                                | Human | Other:            | Describe: |
| Infectious Agents (i.e. HIV, E. Coli, Dengue, West Nile Virus, etc) Please list: |                         |           |  |       |                   |           |
| Viral Vectors Please list:   |                         |           |  |       |                   |           |
| Radioactive Material   |                         | Describe: |  |       |                   |           |
| Formaldehyde:  | <10%                    | >=10%     |  |       |                   |           |
| Where do you work?   | AIP 3rd floor Pathology |           | Research Histology 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 lab / work area. | Protective eye glasses | Yes | No |
|   | Mask/Respirator        | Yes | No |
|   | 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 <b>live</b> animals?      | Yes | No |
| 2. Do you work with whole animal cadavers?    | 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 **YES** to **any of the 3 questions above**, continue to Section 3.0 (complete the entire form).

### Section 3.0 OCCUPATIONAL LABORATORY ANIMAL HISTORY

|   |                                       |        |       |
|---|---------------------------------------|--------|-------|
| 1. I have worked with laboratory animals in the past.                       |                                       | Yes    | No    |
| a. How many months/years did you work with laboratory animals?              |                                       | Months | Years |
| 2. I perform animal handling or procedures in my new position.              |                                       | Yes    | No    |
| Check the boxes below to describe your handling of <b>live</b> lab animals: |                                       |        |       |
| <b>Animal Species</b>   |                                       |        |       |
| Fish/Frogs (other aquatics)   |                                       |        |       |
| Rodents (mice, rats)  |                                       |        |       |
| Hamsters, Gerbils, Guinea Pigs, Chinchillas                                 |                                       |        |       |
| Rabbits   |                                       |        |       |
| Cats  |                                       |        |       |
| Pigs:   | <b>Awake</b> <b>Anesthetized Only</b> |        |       |
| Sheep/Cows  |                                       |        |       |
| Field Work:   |                                       |        |       |
| (Where and what animals?)   |                                       |        |       |
| Other Animal:   |                                       |        |       |
| Describe daily duties/job requirements with Animals:                        |                                       |        |       |

4. Do you have animals at home? Yes No  
Please list the animals:

5. Do you think you are allergic to any animals? Yes No If **no**, go to question 6.  
Please list the animals:

Do you have any of the following types of reactions **around the animals listed above**?

| Reaction                                 | Current Reaction (in last 12 months) |    | Any Prior Reaction |       |
|--|--------------------------------------|----|--------------------|-------|
| a. Runny/Stuffy Nose                     | Yes                                  | No | Yes                | Date: |
| b. Itchy/Reddened Eyes                   | Yes                                  | No | Yes                | Date: |
| c. Cough                                 | Yes                                  | No | Yes                | Date: |
| d. Wheezing                              | Yes                                  | No | Yes                | Date: |
| e. Chest Tightness                       | Yes                                  | No | Yes                | Date: |
| f. Shortness of Breath                   | Yes                                  | No | Yes                | Date: |
| g. Hives/Skin Rash                       | Yes                                  | No | Yes                | Date: |
| h. Throat Swelling/Difficulty Swallowing | Yes                                  | No | Yes                | Date: |
| i. Difficulty Breathing                  | Yes                                  | No | Yes                | Date: |

6. Have you ever experienced an animal-related injury (including bites, scratches or injuries involving cages or equipment) or contracted a disease or infection from animals? Yes No  
Please explain:

### Section 4.0 Medical History

|   |                          |   |
|---|--------------------------|---|
| 1. Have you ever been diagnosed and/or treated for the following diseases/conditions? ( <b>check all that apply</b> ) |                          |   |
| Emphysema   | Irregular Heart Beat     | Please describe history, dates, hospitalizations, medications, etc for all items checked in this section: |
| Chronic Bronchitis/Pneumonia  | Loss of Consciousness    |   |
| Heart Murmur/Valve Disease  | Shortness of Breath      |   |
| Seizures  | Cancer                   |   |
| Diabetes  | High Blood Pressure      |   |
| Epilepsy  | <b>NONE OF THE ABOVE</b> |   |
| Other:  |                          |   |



| Section 5.0 Respiratory Screening   |  |      |
|---|--|------|
| 1. Have you been fitted for a respiratory protection device?  | Yes  | No   |
| a. If YES, what kind and when:  |  |      |
| N-95  | Date:  |      |
| 1/2 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 health and safety that is related to your job?      Yes      No  |  |      |
| Please elaborate:   |  |      |
| Consent for Clinical Services   |  |      |
| <p>I hereby authorize the health care professionals employed or contracted by the University of Colorado Denver   Anschutz Medical Campus to provide education and counseling, recommend appropriate evaluation and follow-up, and maintain medical records created from the clinical appointment. This authorization includes permission to review my immunization and medical history, to obtain routine lab work, and/or provide immunizations and clinical services which may be required (<i>given my job description and risk category</i>).</p> <p>Employee/Applicant Signature: _____</p> <p style="text-align: center;">(If unable to submit, check form for all red highlighted fields and verify these have been completed.)</p> |  |      |
| FOR CLINIC USE ONLY   |  |      |
| <b>Provider Notes:</b>  |  |      |
|   |  |      |
| Enrollment completed: _____ Date: _____<br>Enrollment <b>not</b> completed, pending: _____  |  |      |
| Education and Counseling on Animal Allergies<br>Counseled on injury/first aid/animal bites/scratch procedures<br>Reproductive Health Hazards Counseling given   | Hazardous group education provided<br>Health Counseling<br>Referred for identified hazardous groups<br>Recommend Fit Testing | EHSA |