UNIVERSITY OF CENTRAL ARKANSAS™ | RESEARCH COMPLIANCE

University of Central Arkansas
Occupational Health and Safety for Animal Lab Personnel
HEALTH QUESTIONNAIRE

Please complete every item of this questionnaire and deliver to the Student health Center. **Do not leave anything blank**. The information provided in this questionnaire is protected health information and will not be released to anyone outside of the UCA Student Health Center or to any other agency without consent.

Name: _____ **Birth Date:** _____

Phone Number: _____ **Social Security Number:** _____

Address: _____ **City, State, Zip:** _____

Email: _____ **Sex:** ☐ Male ☐ Female

Job Category: ☐ Animal Care Worker ☐ Researcher ☐ Veterinary ☐ Administrative ☐ Other: _____

1. Please list the animals with which you will be working:

2. Please list the type of contact (if any) you've had in the past with these types of animals:

3. Please list any reactions you've had to animals?

4. Please list the agents with which you will be working (including radiation, chemicals, cleaning products, etc.):

5. Please list any medications that you are using:

6. Please list any medication allergies:

7. Please list any previous hospitalizations or surgeries:

8. Please list any history of chronic rhinitis or sinusitis, asthma, eczema, hives, skin rashes, tongue/throat swelling, anaphylaxis, or positive allergy testing:

9. Please list any history of immunosuppression from medication or medical condition. Examples include HIV/AIDS, cancer, lymphoma, myeloma, chronic steroid use, organ/bone marrow transplantation, sick cell anemia, and spleen injury.

HEALTH QUESTIONNAIRE (continued)

10. Please list any history of heart disease, lung disease, chronic liver disease, chronic kidney disease, or spleen removal:

11. Please list any work restrictions you are currently on due to your health:

12. For workers with animal contact- Please list any problems lifting the cages or pushing/pulling the platforms:

13. Do you have any known latex allergy diagnosed by a medical professional? ☐ Yes ☐ No

14. Are you currently experiencing any of the following:

	Yes	No
Unexplained fatigue, weight loss, or lack of energy?	☐	☐
Unexplained fever, chills, night sweats, or lymph node enlargement?	☐	☐
Severe headaches, visual changes, hearing loss, blackouts, dizziness, weakness, or numbness?	☐	☐
Depression, anxiety, memory loss, irritability, or uncontrolled temper?	☐	☐
Shortness of breath at rest or with activity?	☐	☐
Wheezing, persistent cough, sputum production, or coughing up of blood?	☐	☐
Unexplained chest pains, palpitations, or swelling of the feet?	☐	☐
Persistent nausea, vomiting, abdominal pains, or diarrhea?	☐	☐
Rashes, hives, angioedema, anaphylaxis, or other allergic problems?	☐	☐
Muscle aches, tremors, or weakness?	☐	☐
Swollen and painful joints?	☐	☐
Pain with bending, stooping, or kneeling?	☐	☐
Hearing problems or ringing in the ears?	☐	☐
Other? (please list and describe):	☐	☐

If you answered 'yes' to any of the above items, please provide details here. Please be as specific as possible.

15. Have you had a tuberculosis test in the last year? ☐ Yes ☐ No

16. Date of last tetanus vaccine: _____ ☐ Tetanus/Diphtheria/Pertussis ☐ Tetanus/Diphtheria

Have you received a Pertussis booster as an adult? ☐ Yes ☐ No

17. Have you received the Rabies vaccination series? ☐ Yes ☐ No

If "Yes," please provide the date you completed the series: _____

Reason for being vaccinated: ☐ Post-Exposure ☐ Pre-Exposure

I certify that I have completed the above questions truthfully and completely.

_____ _____

Signature of Animal Lab Personnel **Date**