

## **INITIAL ANIMAL MEDICAL QUESTIONNAIRE**

The purpose of this questionnaire is to help protect you against possible illness that may be caused by working around animals, animal bedding or animal waste. In order to be useful, it is necessary that we review information about what you do in your work, as well as information about your general health status.

- **Completion of the questionnaire is a REQUIREMENT for your job**
  - To receive federal funds for research, the NIH requires an institution to provide an occupational health program to its employees who work with or around animals. In addition, MSU has elected to become accredited by AAALAC which also requires such a program. The program requires MSU to assess the risk to each employee with animal contact.
- **The information you submit is CONFIDENTIAL and will only be reviewed by health professionals within MSU Occupational Health.**
  - The health questions are related to 3 main health issues:
    - 1.) Respiratory allergies including asthma caused by working around animals.
    - 2.) Zoonotic diseases (infectious diseases from animals).
    - 3.) Immunosuppression, which may increase your risk of zoonotic diseases.
- **After reviewing the questionnaire, you will be notified of the results of the review**

We strongly recommend that you become familiar with the hazards associated with your job and use this information to minimize your risk of developing a work-related injury or illness.

For information about the human health hazards of working with the specific animal species you are in contact with, please visit:

<http://safetyservices.ucdavis.edu/article/zoonosis-information-species>

Information about health and safety issues related to working with animals or on a farm is available at the National Ag Safety Database's website:

<https://ag-safety.extension.org/>.

- **Individuals who work with animals may be bitten or scratched by an animal. It is highly recommended that you have a tetanus vaccine every ten years.**

**INITIAL MEDICAL QUESTIONNAIRE FOR  
INDIVIDUALS WITH ANIMAL CONTACT**

Name:			
_____ Last	_____ First	_____ Middle	
Address:			
_____ Street	_____ City	_____ State	_____ Zip
Date of Birth:		ZPID or APID:	
Home Phone:		Job Title:	
Supervisor:		Department:	
What building(s) will you work in?			

Do you or will you work with animals or work in rooms where animals are housed?	Yes	No
➤ If “YES”, what kind of animals do you work with or come in contact with? ➤ If “NO”, what are your job duties?		

Do you or will you work with unfixed animal tissues?	Yes	No
If “YES”, what kind of animals do you work with or come in contact with?		

Do you or will you perform necropsy?	Yes	No
If “YES”, what kind of animals do you work with or come in contact with?		

How long do you plan to work at this job or similar job with animals at MSU?
On the average, how many hours a week do, or will you work/have contact with these animals or specimens?

Height (without shoes):	Weight (without shoes):
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1.	Do you smoke cigarettes now?	Yes	No
2.	Have you had a breathing test? (For example: Spirometry or Pulmonary Function test)	Yes	No
	<b>IF "YES", WHAT WERE THE RESULTS?</b>		
3.	Do you have emphysema?	Yes	No
4.	Do you have asthma?		
	a.	<b>IF "YES", ANSWER QUESTIONS 4b-6. IF "NO", SKIP TO QUESTION 7.</b>	Yes No
	b.	Do you still have it?	Yes No
	c.	Did the doctor confirm it?	Yes No
5.	At what age did your asthma start?		
6.	If you no longer have asthma, what age did it stop?		
7.	Have you ever had tuberculosis?	Yes	No
8.	Have you ever had any other lung problems that you have been told about?	Yes	No
	<b>IF "YES", PLEASE SPECIFY?</b>		
9.	Have you ever had an attack of wheezing that made you feel short of breath?		
	a.	<b>IF "YES", ANSWER QUESTIONS 9b-10. IF "NO", SKIP TO QUESTION 11.</b>	Yes No
	b.	Have you had two or more such episodes?	Yes No
	c.	Have you required medicine or treatment for these attacks?	Yes No
10.	How old were you when your first attack of wheezing occurred?		
11.	Do you bring up phlegm or mucous from your chest? (Count phlegm with first waking up or first cigarette or on first going outdoors or swallowed phlegm. <b>Exclude</b> phlegm from the nose.		
	a.	<b>IF "YES", ANSWER QUESTIONS 11b-12. IF "NO", SKIP TO QUESTION 13.</b>	Yes No
	b.	Do you bring up phlegm or mucous like on 4 or more days per week, for 3 consecutive months or more during the year?	Yes No
12.	For how many years have you had trouble with phlegm or mucous?		

<b>13.</b>	When was your last medical examination?
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<b>14.</b>	Do you have any chronic medical conditions?	Yes	No
	<b>IF "YES", WHAT DISEASE CONDITIONS?</b>		

<b>15.</b>	Do you or did you have cancer or an immune deficiency?	Yes	No
	<b>IF "YES", TYPE AND YEAR OF DIAGNOSIS:</b>		
	Type: _____	Year of Diagnosis: _____	
	Type: _____	Year of Diagnosis: _____	
	Type: _____	Year of Diagnosis: _____	

<b>16.</b>	Do you take medication that may suppress your immune system? (Examples of such medications are prednisone or other steroids, chemotherapy or the anti-cancer agents, methotrexate, or Cytosan.)	Yes	No
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<b>17.</b>	Have you ever been told you have allergies?	Yes	No
	<b>IF "YES", INDICATE WHAT SUBSTANCES AND AT WHAT AGE YOUR ALLERGIES BEGAN?</b>		
	Substance: _____	Age started: _____	
	Substance: _____	Age started: _____	
	Substance: _____	Age started: _____	

<b>18.</b>	Have you ever had allergy skin testing?	Yes	No
	<b>IF "YES", HOW MANY DIFFERENT POSITIVE SKIN TESTS TO NON-ANIMAL SUBSTANCES DID YOU HAVE? (Estimate if you don't know exact number)</b>		
	List animals you had positive skin tests to:		
	_____		
	_____		

<b>19.</b>	Have you had any of the following types of reactions <b>when around animals?</b>		
<b>a.</b>	Runny/Stuffy Nose	Yes	No
<b>b.</b>	Itching Eyes	Yes	No
<b>c.</b>	Cough	Yes	No
<b>d.</b>	Wheezing	Yes	No
<b>e.</b>	Chest Tightness	Yes	No
<b>f.</b>	Shortness of Breath	Yes	No
<b>g.</b>	Skin Rash	Yes	No
	<b>IF "YES", WHAT ANIMALS?</b>		

<b>20.</b>	Have you ever taken medication for allergies (either needing a doctor's prescription or those you can buy yourself?	Yes	No
	<b>IF "YES", LIST MEDICATION(S) AND YEAR(S) TAKEN?</b>		
	Medication: _____ Year(s) taken: _____		
	Medication: _____ Year(s) taken: _____		
	Medication: _____ Year(s) taken: _____		
	Medication: _____ Year(s) taken: _____		

<b>21.</b>	Have you had problems with your bowels?		
<b>a.</b>	Blood in your stool	Yes	No
<b>b.</b>	Black stool (not dark brown)	Yes	No
<b>c.</b>	Diarrhea lasting 1 day or more?	Yes	No
	<b>IF "YES", HOW MANY TIMES PER YEAR?</b>		

<b>22.</b>	List all medications you take on a regular basis (include those you can buy without a prescription). If you don't know the name, list what the pill is for (For example: heart pill or water pill).	
	_____ for _____	_____ for _____
	_____ for _____	_____ for _____
	_____ for _____	_____ for _____
	_____ for _____	_____ for _____

23.	Are you exposed to <b>HUMAN</b> blood or body fluids? (For example: working with human controls/samples or work in the incinerator)	Yes	No
<b>IF "YES", HEPATITIS B SURVEILLANCE PROGRAM FORM MUST BE COMPLETED. THE FORM IS LOCATED ONLINE AT:</b> <a href="https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/HepBSurveillance.pdf">https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/HepBSurveillance.pdf</a>			
24.	Do you have an increased work-related risk of exposure to rabies?	Yes	No
<p>➤ Answer <b>"YES"</b>, if you work with Non-Lab Mammals that come from outside MSU's campus or Unfixed Saliva specimens that may contain brain or nerve tissue from mammals.</p> <p>➤ ANSWER <b>"NO"</b>, if you work with <b>ONLY</b> lab animals or animals that live in MSU controlled areas.</p> <p><b>IF YOU HAVE AN INCREASES RABIES RISK, YOU MUST COMPLETE THE RABIES SURVEILLANCE RECORD. THE FORM IS LOCATED ONLINE AT:</b>  <a href="https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/RabiesSurveillanceSheetwithvaccinerecord.pdf">https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/RabiesSurveillanceSheetwithvaccinerecord.pdf</a> </p>			
25.	Have you had a tetanus vaccine in the last 10 years	Yes	No
26.	Do you think you will be required to wear a respirator as part of your regular work or if there is an emergency?	Yes	No
<b>IF "YES", please complete Initial Medical Questionnaire for Individuals Who Wear a Respirator:</b> <a href="https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/Initial-Respirator.pdf">https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/Initial-Respirator.pdf</a>			
27.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	Yes	No

**You are done! Please mail, email or fax this completed questionnaire to: MSU Occupational Health, 463 E. Circle Drive, Room 123, East Lansing, MI 48824 (located in Olin Health Center). Fax: (517) 355-0332 or Email: [HT.occhealth@msu.edu](mailto:HT.occhealth@msu.edu)**