Michigan State University
Occupational Health
East Lansing, MI 48824-1037
(517) 353-9137

INTERIM 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.**

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INTERIM 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 ☐
	IF "YES", WHAT WERE THE RESULTS?		

3.	During the past year, for each of the following symptoms, indicate if you were bothered by the **symptom(s) at work**. If you have the symptom(s), give the month and year you began to have the symptom(s).			
a.	Itchy or irritated eyes	Yes ☐	No ☐	Month/Year
b.	Nasal stuffiness	Yes ☐	No ☐	
c.	Runny nose	Yes ☐	No ☐	
d.	Sore or dry throats	Yes ☐	No ☐	
e.	Wheezing	Yes ☐	No ☐	
f.	Cough	Yes ☐	No ☐	
g.	Chest tightness	Yes ☐	No ☐	
h.	Shortness of breath	Yes ☐	No ☐	
i.	Skin rash	Yes ☐	No ☐	

- **IF "YES", TO ANY SYMPTOM IN QUESTION "3", PLEASE ANSWER QUESTION "4 - 4h".**
- **IF "NO", SKIP TO QUESTION "5".**

4.	Have you ever had to seek medical treatment for symptom(s)?	Yes ☐	No ☐

4a.	Name the type of medical care, month/year you first sought medical care and how many times you used that source of medical care?			
Olin Health Center	Yes ☐	No ☐	Month/Year first seen by Physician	Number of Visits
Personal Physician	Yes ☐	No ☐	Month/Year first seen by Physician	Number of Visits
Emergency Room	Yes ☐	No ☐	Month/Year first seen by Physician	Number of Visits
Hospitalizations	Yes ☐	No ☐	Month/Year first seen by Physician	Number of Visits

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4b.	In the last year, have you missed work or had to leave work early because of any of these medical symptoms?	Yes ☐	No ☐
	IF "YES", WHICH SYMPTOM(S)?		

4c.	Do you find that many things cause symptoms or are your symptoms specific to one or certain things?		
I.	One thing	Yes ☐	No ☐
II.	Many things	Yes ☐	No ☐
III.	A number of specific things	Yes ☐	No ☐

4d.	What thing(s) or specific duties **<u>at work</u>** do you believe are causing the symptoms?

4e.	Are you still exposed to the things causing symptoms? ➢ **IF "NO", GIVE MONTH/YEAR LAST EXPOSED AND INDICATE WHY NO LONGER EXPOSED.**				
Been reassigned		Yes ☐	No ☐	Month/Year last exposed:	Indicate why no longer exposed:
Type of animal replaced		Yes ☐	No ☐	Month/Year last exposed:	Indicate why no longer exposed:
New engineering controls		Yes ☐	No ☐	Month/Year last exposed:	Indicate why no longer exposed:
Left job		Yes ☐	No ☐	Month/Year last exposed:	Indicate why no longer exposed:
Other		Yes ☐	No ☐	Month/Year last exposed:	Indicate why no longer exposed:

4f.	Are the symptoms still present	Yes ☐	No ☐

4g.	If you had (have) wheezing, cough, chest tightness or shortness of breath, answer the following:		
Did the symptoms get worse during the day when you worked?		Yes ☐	No ☐
Are the symptoms worse on Monday or first day back to work (if you work weekends)?		Yes ☐	No ☐

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Did the symptoms get better when you were away from work or on the weekends or vacations?	Yes ☐	No ☐
Did symptoms get worse when you went home after work?	Yes ☐	No ☐
Did the symptoms get worse throughout the work week?	Yes ☐	No ☐

4h.	Do you take medication for your breathing problem?	Yes ☐	No ☐
	IF "YES", LIST MEDICATION(S) AND YEAR(S) TAKEN? Medication: _____ Month/Year Started: _____ Medication: _____ Month/Year Started: _____ Medication: _____ Month/Year Started: _____		

5.	Do you take medication now?	Yes ☐	No ☐
	IF "YES", LIST YOUR CURRENT MEDICATION(S)? Medication: _____ Medication: _____ Medication: _____ Medication: _____ Medication: _____ Medication: _____ Medication: _____ Medication: _____		

6.	Did you have allergy testing in the past year?	Yes ☐	No ☐

7.	Since completing your last animal contact questionnaire, have you had any other chest illness?	Yes ☐	No ☐
	IF "YES", PLEASE SPECIFY?		

8.	Have you been diagnosed with cancer or immune deficiency?	Yes ☐	No ☐
	IF "YES", PLEASE SPECIFY?		

9.	Since completing your last animal contact questionnaire, have you had diarrhea lasting 1 day or more?	Yes ☐	No ☐
	IF "YES", PLEASE ESTIMATE HOW MANY TIMES IN THE PAST YEAR?		

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10.	Have you seen a doctor for diarrhea?	Yes ☐	No ☐
	IF "YES", WHAT WA YOUR DIAGNOSIS?		

11.	Have you seen a doctor for skin rash?	Yes ☐	No ☐
	IF "YES", WHAT WAS YOUR DIAGNOSIS?		

12.	Have you had a tetanus vaccine in the last 10 years	Yes ☐	No ☐

13.	Do you think you will be required to wear a respirator as part of your regular work or if there is an emergency? ➢ **IF "YES", PLEASE PROCEED TO QUESTION 13a OR 13b BELOW:**	Yes ☐	No ☐
a.	Complete the "**Initial**" Medical Questionnaire for Individuals Who Wear a Respirator **if this is the first time** you are completing the respirator questionnaire: **https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/Initial-Respirator.pdf**		
b.	You are done unless you are due for your respirator certification. You may check your status at **http://www.herd.msu.edu/.** If the expiration of your respirator certification is in a few months or past due, you will need to complete the "**Interim**" Medical Questionnaire for Individuals Who Wear a Respirator: **https://edge.sitecorecloud.io/michigansta4a14-msu70a4-prod718c-8cd0/media/Project/MSU/UHW/Docs/Interim-Respirator.pdf**		

14.	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

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