SAINT LOUIS UNIVERSITY
EST. 1818

# O H P

# Occupational Health Program for Laboratory and Animal Research

## INSTRUCTIONS

Print all information clearly
Complete the packet without leaving blanks - put “NO” or “N/A” (not applicable) if needed

After completing the packet, please return it to OHP office
This can be done one of two ways

1. Interoffice mail – Dr. Steven Cummings – School of Medicine – Doisy Hall – Room R311
2. Scan/Email – steven.cummings@health.slu.edu

After reviewing your responses, OHP office medical staff may contact you to discuss the need for further medical evaluation

If you would like medical evaluation at any time related to potential work exposures, contact OHP office

For any questions about the Occupational Health program, contact OHP office at 314-977-7026

# Saint Louis University

## Occupational Health Program for Laboratory and Animal Research

### Background

Regulatory and funding agencies require that Saint Louis University offer an Occupational Health Program (OHP). Each person listed on an Animal Use Protocol approved by the Institutional Animal Care and Use Committee (IACUC) must be informed about the OHP and be afforded the opportunity to participate. Prior to approval of an animal use protocol, IACUC must be able to confirm that each person listed on the protocol has been offered the OHP.

The OHP program centers around four things:

1. Medical history evaluation.
    a. Participants are asked to complete this questionnaire to obtain information about personal health as it relates to potential work exposure to biological pathogens, recombinant DNA, and/or laboratory animals.
    b. The OHP medical questionnaire is completed by each participant by following the INSTRUCTIONS on the front cover page.
    c. The OHP medical questionnaire is reviewed by the OHP office with attention to animal allergies, ergonomics, and immune suppression issues.
    d. This questionnaire may be completed at the time of hire, if work starts on a new protocol, or at intervals while working on an existing protocol.
    e. This information will become part of the individual's OHP record. This will NOT become part of a personnel/HR record, a medical record, or a hospital record.
    f. Instructions for returning documentation are on the front cover page.
2. Tetanus immunization every 10 years. OHP office will advise each participant should an update be needed.
3. Tuberculosis screening. OHP office will advise each participant should an update be needed.
4. Evaluation of work related injuries and illnesses.
    a. Should a work-related injury or illness occur related to this project, the involved worker should report it immediately to their supervisor.
    b. An Employee Report of Injury form must be completed and turned into SLU Risk Management.
    c. The supervisor should phone ahead to advise either Concentra (314) 421-2557 or SSM Health Saint Louis University Hospital Emergency Room (314) 257-1320 of the incident and of the incoming exposed/injured worker.
    d. The injured worker should be referred to:
        Concentra Urgent Care
        3100 Market Street, St. Louis, MO 63103
        Hours: 8:00am to 5:00pm - Monday to Friday excluding holidays
    e. If the work-related injury or illness occurs outside business hours or if the work-related injury is severe, the injured worker should report to the Emergency Room at SSM Health Saint Louis University Hospital. Call 911 for work injuries if needed.
        If the initial treatment occurs in the ER, the injured worker MUST follow up with Concentra on the next business day.

OHP

# REGISTRATION INFORMATION

NAME_____Date _____

☐University ☐SSM ☐Other _____

OCCUPATION _____

DEPARTMENT_____SHIFT _____

SUPERVISOR_____SUPERVISOR PHONE _____

SOCIAL SECURITY NUMBER (last four) _____ _____ _____ _____

BANNER NUMBER (University) _____

BIRTHDATE _____--_____--_____ AGE _____ SEX ☐FEMALE ☐MALE

MARITAL STATUS ☐single ☐married Religious preference (optional) _____

HOME ADDRESS _____

_____ZIP_____

HOME PHONE_____WORK PHONE _____

PAGER #_____CELL # _____

BIRTH COUNTRY_____# OF YEARS IN THE U.S. _____

CURRENT MEDICATIONS _____

_____

_____

ALLERGIES _____

LAST TETANUS SHOT _____

OHP

| | YES | NO | Mark YES to medical conditions that you have now or have had in the past. Mark NO to medical conditions you have never had. **Make a mark for each question. Per regulations, we cannot accept lines drawn down the NO column.** |
|---|---|---|---|
| 1 | | | Chickenpox disease in the past |
| 2 | | | Fatigue |
| 3 | | | Allergic Reactions |
| 4 | | | Rashes |
| 5 | | | Skin diseases/Dermatitis |
| 6 | | | Scars |
| 7 | | | Identifying Marks |
| 8 | | | Hives/Chronic Itching |
| 9 | | | Glove Powder Reaction |
| 10 | | | Watery Eyes |
| 11 | | | Nasal Congestion |
| 12 | | | Wheezing |
| 13 | | | Reactions to Animals |
| 14 | | | Latex Reaction |
| 15 | | | Head Injury/Skull Fracture |
| 16 | | | Headaches-chronic/frequent |
| 17 | | | Memory Trouble |
| 18 | | | Epilepsy/Seizures/Convulsions/Fits |
| 19 | | | Mental Trouble |
| 20 | | | Concussion |
| 21 | | | Fainting/Lightheadedness |
| 22 | | | Dizzy/Balance Trouble |
| 23 | | | Loss of Consciousness |
| 24 | | | Stroke |
| 25 | | | Paralysis |
| 26 | | | Thinking Trouble |
| 27 | | | Sleep Disorder |
| 28 | | | Glasses and/or Contacts |
| 29 | | | Blindness |
| 30 | | | Color Blindness |
| 31 | | | Glaucoma |
| 32 | | | Cataracts |
| 33 | | | Eye Disease/Eye Trouble |
| 34 | | | Decreased Hearing |
| 35 | | | Draining Ear |
| 36 | | | Ringing in the Ears |
| 37 | | | Ruptured Eardrum |
| 38 | | | Hearing Aid |
| 39 | | | Hay Fever/Allergies |
| 40 | | | Frequent Sore Throats |

OHP

| | YES | NO | Mark YES to medical conditions that you have now or have had in the past. Mark NO to medical conditions you have never had. **Make a mark for each question. Per regulations, we cannot accept lines drawn down the NO column.** |
|---|---|---|---|
| 41 | | | Sinus Trouble |
| 42 | | | Tonsillectomy +/- Adenoids |
| 43 | | | Tuberculosis Disease |
| 44 | | | Positive PPD Previously Documented |
| 45 | | | BCG Vaccination |
| 46 | | | INH Therapy in the Past |
| 47 | | | Chronic Cough |
| 48 | | | Coughing Up Blood |
| 49 | | | Weight Loss Unexplained |
| 50 | | | Night Sweats |
| 51 | | | Fever Unexplained |
| 52 | | | Chest Pain |
| 53 | | | Current Smoker |
| 54 | | | Previous Smoker |
| 55 | | | Never Smoker |
| 56 | | | Pneumonia |
| 57 | | | Asthma/Wheezing |
| 58 | | | Emphysema/COPD |
| 59 | | | Chronic Bronchitis |
| 60 | | | Shortness of Breath |
| 61 | | | Respirator Use in Past |
| 62 | | | Collapsed Lung |
| 63 | | | Heart Trouble |
| 64 | | | Heart Attack/Artery Block |
| 65 | | | Palpitations |
| 66 | | | Heart Valve Trouble |
| 67 | | | High Blood Pressure/Hypertension |
| 68 | | | Low Blood Pressure |
| 69 | | | Carotid Artery Disease |
| 70 | | | Ulcer |
| 71 | | | Indigestion/Stomach Trouble |
| 72 | | | Gallbladder disease |
| 73 | | | Appendicitis |
| 74 | | | Liver Disease/Jaundice |
| 75 | | | Hepatitis A |
| 76 | | | Hepatitis B |
| 78 | | | Hepatitis C |
| 79 | | | Diabetes |
| 80 | | | Pancreas Disease |
| 81 | | | Thyroid Disease |
| 82 | | | Weight Gain |
| 83 | | | Blood in Stools |
| 84 | | | Kidney Disease/Kidney Stones |
| 85 | | | Hemorrhoids |
| 86 | | | Constipation |
| 87 | | | Hernia |
| 88 | | | Blood/Infection of Urine |
| 89 | | | Neck(cervical spine) injury/strain/pain/fracture/surgery |
| 90 | | | Thoracic spine injury/strain/pain/fracture/surgery |

OHP

| | YES | NO | Mark YES to medical conditions that you have now or have had in the past. Mark NO to medical conditions you have never had. **Make a mark for each question. Per regulations, we cannot accept lines drawn down the NO column.** |
|---|---|---|---|
| 91 | | | Lumbar (low back) spine injury/strain/pain/fracture/surgery |
| 92 | | | Finger/Hand/Wrist injury/strain/pain/fracture/surgery |
| 93 | | | Elbow injury/strain/pain/fracture/surgery |
| 94 | | | Shoulder injury/strain/pain/fracture/surgery |
| 95 | | | Toe/Foot/Ankle injury/strain/pain/fracture/surgery |
| 96 | | | Knee injury/strain/pain/fracture/surgery |
| 97 | | | Hip injury/strain/pain/fracture/surgery |
| 98 | | | Arthritis/Rheumatism/Joint pain/swelling |
| 99 | | | Swelling legs/ankles |
| 100 | | | Varicose Veins/Leg Ulcers |
| 101 | | | Gout |
| 102 | | | Amputation/Deformity |
| 103 | | | Cancer/Tumor |
| 104 | | | Anemia/Bleeding/Bruises |
| 105 | | | Blood disease/Leukemia |
| 106 | | | Gynecological Disease/Surgery |
| 107 | | | Prostate Disease/Surgery |
| 108 | | | Surgeries/operations |
| 109 | | | Hospitalizations |
| 110 | | | Fear of Heights |
| 111 | | | Fear of Small Places |
| 112 | | | Prior Military Service |
| 113 | | | Rejected for Military Service |
| 114 | | | Rejected for Life Insurance |
| 115 | | | Rejected for Employment |
| 116 | | | Drink Alcoholic Beverages |
| 117 | | | Recreational Drug Use |
| 118 | | | Smokeless Tobacco Product Use |
| 119 | | | Do you have any abnormal/decreased sensation/numbness/tingling in the fingers/hands/wrists/forearms? |
| 120 | | | Are you presently under the care of a physician? |
| 121 | | | Do you have any previous work-related injury? |

_____

Patient PRINTED Name

_____ _____--_____--_____

Patient Signature Date

OHP

# Laboratory Animal Exposure History

1. _____ **Animal Protocol number(s) for this OHP enrollment if known**
2. ☐Yes ☐ No **Have you ever worked with laboratory animals?**
3. _____(months) **How many months have you worked with laboratory animals?**
4. **Check the boxes below if you have been in contact with animals and specify contact hours/day, total duration, months at SLU.**

| ANIMAL | Previously | Currently | Never | Contact Hours/Day | Total Months | Months At SLU |
|---|---|---|---|---|---|---|
| Rats | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Mice | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Rabbits | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Guinea Pigs | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Old World Monkeys (Baboon, Macaque, etc.) | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| New World Monkeys (Squirrel, Marmoset, etc.) | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Cattle | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Dogs | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Hamsters | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Gerbils | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Prairie Dogs | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Sheep | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Goats | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Swine | ☐ | ☐ | ☐ | _____ | _____ | _____ |
| Other | ☐ | ☐ | ☐ | _____ | _____ | _____ |

If other, please specify: _____

5. ☐Yes ☐No **Do you think that you are allergic to any of these animals?**
If yes, please check all that apply:
☐ Rats ☐ Mice ☐ Rabbits ☐ Guinea Pigs ☐ Monkeys ☐ Cattle
☐ Dogs ☐ Cats ☐ Hamsters ☐ Gerbils ☐ Prairie Dogs ☐ Dogs
☐ Sheep ☐Goats ☐ Swine ☐ Other (specify) _____

6. ☐Yes ☐No **Have you ever had any problems working around animals?**

If yes, please explain: _____

7. ☐Yes ☐No **Do you currently experience problems working around animals?**

If yes, please explain: _____

8. ☐Yes ☐No **Do you have any of the following symptoms when working with animals?**
If yes, please check all that apply:
☐ Hand rash ☐ Other rash ☐Itchy eyes ☐ Watery eyes ☐ Runny nose ☐ Scratchy throat
☐ Cough ☐ Wheezing ☐ Trouble breathing ☐ Other (specify) _____

9. **Do you use or wear any of the following items when working with animals?**

| | | | |
|---|---|---|---|
| Protective Eyewear | ☐ Yes | ☐ Sometimes | ☐ No |
| Mask | ☐ Yes | ☐ Sometimes | ☐ No |
| Respirator | ☐ Yes | ☐ Sometimes | ☐ No |
| Lab Coat | ☐ Yes | ☐ Sometimes | ☐ No |
| Gloves | ☐ Yes | ☐ Sometimes | ☐ No |

10. **Are any agents of the following hazardous groups used in these animals?**
☐ Infectious ☐ Teratogenic/Carcinogenic ☐ Radioactive ☐ Other: _____

Please list if checked: _____

OHP

## Allergy History

11. ☐Yes ☐No **Have you ever been skin tested for allergies?**
    If yes, what substances were you found to be allergic to or sensitized to?
    ☐ Ragweed ☐ Grass ☐ Trees ☐ Mold ☐ Mice
    ☐ Dust ☐ Cat ☐ Dog ☐ Other: _____

12. ☐Yes ☐No **Have you ever received allergy (desensitization/immunotherapy) shots?**
    If yes, what year did you receive the shots? _____

13. ☐Yes ☐No **Do any of your blood relatives (grandparents, parents, brothers/sisters) have allergies or asthma?**

14. ☐Yes ☐No **Are you allergic to latex?**
    If yes, please describe your symptoms. _____

15. ☐Yes ☐No **Do you have any indoor pets?**
    If yes, which animals and for how long?

| Animal | 1-2 Years | 2-3 Years | 3-4 Years | Over 4 Years |
|---|---|---|---|---|
| Dogs | ☐ | ☐ | ☐ | ☐ |
| Cats | ☐ | ☐ | ☐ | ☐ |
| Other (Type): _____ | ☐ | ☐ | ☐ | ☐ |

16. **What type of fuel do you use at home?**
    Cooking: ☐ Electricity ☐ Gas/propane ☐ Oil ☐ Wood ☐ Other _____
    Heating: ☐ Electricity ☐ Gas/propane ☐ Oil ☐ Wood ☐ Other _____

17. ☐Yes ☐No **Do you have roaches in your home?**

18. ☐Yes ☐No **Do you have non-pet mice or other animals in your home?**

## Recombinant DNA Pre-Exposure Screening

19. ☐Yes ☐No **Are you involved with recombinant DNA technology or microorganisms that contain recombinant DNA?**

20. ☐Yes ☐No **Does the research involve techniques in which viable, recombinant DNA-containing microorganisms are used to infect animals that require Bio-safety level 2 or 3 containment?**
    If yes, please explain: _____

21. ☐Yes ☐No **Do you have any diseases (lupus, cancer, etc.) that suppress your immune system?**
    If yes, please describe your symptoms. _____

22. ☐Yes ☐No **Do you currently take any mediations that may suppress your immune system?**
    If yes, please describe your symptoms. _____

23. ☐Yes ☐No **Do you have any other health conditions that you think could be adversely affected by your work?**
    If yes, please describe your symptoms. _____

24. Other Comments: _____

## Attestation and Signature

There may be increased occupational health risks associated if your work situation(s) change. At any time after completing this questionnaire, you are strongly encouraged to contact OHP office to receive occupational health evaluation, 1)if you become pregnant or if you start planning to become pregnant, 2)if you become aware of a change in your health status, 3)if the species of animal/pathogen that you are exposed to at work changes.

_____
Patient PRINTED Name

_____ _____--_____--_____
Patient Signature Date