



SAINT LOUIS
UNIVERSITY

Occupational Health Program for Laboratory and Animal Research

Medical History Questionnaire

The Medical Component of the Occupational Health Program (OHP) centers around three things:

1. Medical History Evaluation

- a. The purpose of the OHP Medical History Questionnaire (MQ) is to obtain information about personal health as it relates to potential work exposure to biological pathogens, recombinant DNA, and/or laboratory animals.
- b. The MQ should be completed by each participant. Personnel should follow the instructions on page two of this document. The completed medical questionnaire is reviewed by Employee Health with attention to animal allergies, ergonomics, and immune suppression issues.
- c. Personnel may decline the medical services portion of the program by filling out the declination form (last page) in addition to the MQ. In order to decline medical service BOTH the MQ and the declination form must be signed and returned to Employee Health.

Please Note: Declining the medical services of the Occupational Health Program may prevent a worker from participating in certain research that is part of their job or project. Workers should discuss declination with supervisor prior to completing the form.

- d. Instructions for returning documentation to Employee Health are listed on page two.

2. Tetanus immunization every 10 years

- a. Employee Health will advise each participant if an update is needed.

3. Evaluation of work related injuries and illnesses

- a. Should a work-related injury or illness occur related to work in laboratory and/or animal research facilities, the involved employee must report it immediately to their supervisor, and an Employee Report of Injury Form must be completed.
- b. The supervisor should phone ahead to advise either Employee Health or SLU Hospital Emergency Room of the incident and incoming exposed patient.
- c. The injured employee should be referred to:
Employee Health
SLU Hospital West Pavilion (enter off Rutger Street)
Hours: 7:30 am to 4:00 pm Monday-Friday (excluding holidays)
- d. If the work related injury or illness occurs outside business hours or if the work related injury is severe, the injured employee should report to the Emergency Room at SLU Hospital.
 - i. If the initial treatment occurs in the ER, the injured employee MUST follow up with Employee Health on the next working day. An original Employee Report of Injury Form must be provided to Employee Health at the time of evaluation.

Saint Louis University
Occupational Health Program for Laboratory and Animal Research

MEDICAL HISTORY QUESTIONNAIRE

INSTRUCTIONS

You are being asked to complete this questionnaire to obtain information about your personal health as it relates to potential work exposure to biological pathogens, recombinant DNA, and/or laboratory animals. Various regulatory and oversight agencies require that all research institutions (including SLU) have such an occupational health program. This questionnaire may be completed at the time of hire, if you start working on a new protocol, or at intervals while working on an existing protocol.

- **The information you provide in this form will become part of your Employee Health record.** This information will NOT become part of your SLU personnel record, a SLUCare medical record, or a hospital medical record.
- After completing the questionnaire, please submit it to Employee Health (EH). To ensure confidentiality, it is best to use the EH secure, confidential fax line: 314-268-56; 2. You can keep the original for your own records after you check the fax confirmation from your machine. Alternatively, the form can be interoffice mailed to EH. If mailed, it is recommended that you keep a copy for your own records.
 - Employee Health (Confidential)
 - 3655 Vista Avenue, West Pavilion Suite 116
- After reviewing your responses, Employee Health may contact you to discuss the need for further medical evaluation. If you would like further medical evaluation at any time related to potential work exposures, contact Employee Health.
- Even if you decline medical services, complete the Medical History sections prior to signing the medical services declination form and returning it to Employee Health.
- For any questions about the Occupational Health Program, contact:

Employee Health at 314-268-5499



Employee Health



REGISTRATION INFORMATION

NAME _____ Date: _____

Tenet University Other _____

OCCUPATION: _____

DEPARTMENT _____ SHIFT _____

SUPERVISOR _____ SUPERVISOR PHONE _____

SOCIAL SECURITY NUMBER (last four digits) XXX--XX-- _____

BIRTHDATE ____ -- ____ -- ____ AGE ____ SEX FEMALE MALE

MARITAL STATUS single married Religious preference (optional) _____

HOME ADDRESS _____

_____ ZIP _____

HOME PHONE _____ WORK PHONE _____

PAGER # _____ CELL # _____

EMAIL _____

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

CURRENT MEDICATIONS _____

ALLERGIES _____



Employee Health



providing work related healthcare services for employees of Saint Louis University and Saint Louis University Hospital-Tenet Healthcare

3655 Vista Avenue, West Pavilion Suite 116

St. Louis, MO 63110-2539

phone – 314-268-5499

fax – 314-268-56; 2

FORM VERSION 5 (06MAY2014)



Employee Health



MEDICAL HISTORY--Please mark YES for medical conditions that you have now or have had in the past. For each YES marked item, please write explanation in the space provided provided. Mark NO for all others.

<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
<input type="checkbox"/>	<input type="checkbox"/> chicken pox in _____ (year)	<input type="checkbox"/>	<input type="checkbox"/> tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> kidney trouble/stones
<input type="checkbox"/>	<input type="checkbox"/> fatigue	<input type="checkbox"/>	<input type="checkbox"/> history of positive PPD	<input type="checkbox"/>	<input type="checkbox"/> hemorrhoids/piles
<input type="checkbox"/>	<input type="checkbox"/> allergic reactions	<input type="checkbox"/>	<input type="checkbox"/> BCG vaccination	<input type="checkbox"/>	<input type="checkbox"/> constipation
<input type="checkbox"/>	<input type="checkbox"/> rashes	<input type="checkbox"/>	<input type="checkbox"/> INH therapy in the past	<input type="checkbox"/>	<input type="checkbox"/> hernia/rupture
<input type="checkbox"/>	<input type="checkbox"/> skin diseases/dermatitis	<input type="checkbox"/>	<input type="checkbox"/> chronic cough	<input type="checkbox"/>	<input type="checkbox"/> blood/infection of urine
<input type="checkbox"/>	<input type="checkbox"/> scars	<input type="checkbox"/>	<input type="checkbox"/> coughing up blood	<input type="checkbox"/>	<input type="checkbox"/> back pain
<input type="checkbox"/>	<input type="checkbox"/> identifying marks	<input type="checkbox"/>	<input type="checkbox"/> unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/> back injury
<input type="checkbox"/>	<input type="checkbox"/> hives/chronic itching	<input type="checkbox"/>	<input type="checkbox"/> night sweats	<input type="checkbox"/>	<input type="checkbox"/> back surgery
<input type="checkbox"/>	<input type="checkbox"/> glove powder reaction	<input type="checkbox"/>	<input type="checkbox"/> fever	<input type="checkbox"/>	<input type="checkbox"/> lumbar strain
<input type="checkbox"/>	<input type="checkbox"/> watery eyes	<input type="checkbox"/>	<input type="checkbox"/> chest pain	<input type="checkbox"/>	<input type="checkbox"/> swollen joints
<input type="checkbox"/>	<input type="checkbox"/> nasal congestion	<input type="checkbox"/>	<input type="checkbox"/> current smoker	<input type="checkbox"/>	<input type="checkbox"/> arthritis
<input type="checkbox"/>	<input type="checkbox"/> wheezing	<input type="checkbox"/>	_____ packs per day for _____ years	<input type="checkbox"/>	<input type="checkbox"/> hand/wrist trauma
<input type="checkbox"/>	<input type="checkbox"/> reactions to animals	<input type="checkbox"/>	<input type="checkbox"/> previous smoker	<input type="checkbox"/>	<input type="checkbox"/> hand/wrist fracture
<input type="checkbox"/>	<input type="checkbox"/> latex reaction	<input type="checkbox"/>	quit in _____ (year)	<input type="checkbox"/>	<input type="checkbox"/> swelling legs/ankles
<input type="checkbox"/>	<input type="checkbox"/> head injury/skull fracture	<input type="checkbox"/>	<input type="checkbox"/> pneumonia	<input type="checkbox"/>	<input type="checkbox"/> varicose veins/leg ulcer
<input type="checkbox"/>	<input type="checkbox"/> frequent headaches	<input type="checkbox"/>	<input type="checkbox"/> asthma/wheezing	<input type="checkbox"/>	<input type="checkbox"/> gout
<input type="checkbox"/>	<input type="checkbox"/> memory trouble	<input type="checkbox"/>	<input type="checkbox"/> emphysema	<input type="checkbox"/>	<input type="checkbox"/> deformity
<input type="checkbox"/>	<input type="checkbox"/> epilepsy/convulsions/fits	<input type="checkbox"/>	<input type="checkbox"/> chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/> amputation
<input type="checkbox"/>	<input type="checkbox"/> mental trouble	<input type="checkbox"/>	<input type="checkbox"/> shortness of breath	<input type="checkbox"/>	<input type="checkbox"/> rheumatism
<input type="checkbox"/>	<input type="checkbox"/> concussion	<input type="checkbox"/>	<input type="checkbox"/> worn a respirator	<input type="checkbox"/>	<input type="checkbox"/> stiff joints
<input type="checkbox"/>	<input type="checkbox"/> fainting/lightheadedness	<input type="checkbox"/>	<input type="checkbox"/> collapsed lung	<input type="checkbox"/>	<input type="checkbox"/> broken bones/fractures
<input type="checkbox"/>	<input type="checkbox"/> dizzy/balance problem	<input type="checkbox"/>	<input type="checkbox"/> chest discomfort	<input type="checkbox"/>	<input type="checkbox"/> cancer
<input type="checkbox"/>	<input type="checkbox"/> loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/> heart trouble	<input type="checkbox"/>	<input type="checkbox"/> operations/surgery
<input type="checkbox"/>	<input type="checkbox"/> stroke	<input type="checkbox"/>	<input type="checkbox"/> heart attack/artery block	<input type="checkbox"/>	<input type="checkbox"/> hospitalizations
<input type="checkbox"/>	<input type="checkbox"/> paralysis	<input type="checkbox"/>	<input type="checkbox"/> palpitations	<input type="checkbox"/>	<input type="checkbox"/> tumor
<input type="checkbox"/>	<input type="checkbox"/> thinking trouble	<input type="checkbox"/>	<input type="checkbox"/> heart valve trouble	<input type="checkbox"/>	<input type="checkbox"/> anemia/bleeding/bruises
<input type="checkbox"/>	<input type="checkbox"/> sleep disorder	<input type="checkbox"/>	<input type="checkbox"/> high blood pressure	<input type="checkbox"/>	<input type="checkbox"/> blood disease/leukemia
<input type="checkbox"/>	<input type="checkbox"/> glasses	<input type="checkbox"/>	<input type="checkbox"/> low blood pressure	<input type="checkbox"/>	<input type="checkbox"/> fear of heights
<input type="checkbox"/>	<input type="checkbox"/> contacts	<input type="checkbox"/>	<input type="checkbox"/> carotid disease	<input type="checkbox"/>	<input type="checkbox"/> fear of small places
<input type="checkbox"/>	<input type="checkbox"/> blindness	<input type="checkbox"/>	<input type="checkbox"/> ulcer-indigestion	<input type="checkbox"/>	<input type="checkbox"/> drink alcohol beverages
<input type="checkbox"/>	<input type="checkbox"/> color blindness	<input type="checkbox"/>	<input type="checkbox"/> stomach trouble	<input type="checkbox"/>	how much? _____
<input type="checkbox"/>	<input type="checkbox"/> glaucoma	<input type="checkbox"/>	<input type="checkbox"/> gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/> recreational drug use
<input type="checkbox"/>	<input type="checkbox"/> cataracts	<input type="checkbox"/>	<input type="checkbox"/> appendicitis	<input type="checkbox"/>	<input type="checkbox"/> prior military service
<input type="checkbox"/>	<input type="checkbox"/> eye trouble	<input type="checkbox"/>	<input type="checkbox"/> liver disease/jaundice	<input type="checkbox"/>	<input type="checkbox"/> rejected for military
<input type="checkbox"/>	<input type="checkbox"/> decreased hearing	<input type="checkbox"/>	<input type="checkbox"/> hepatitis A	<input type="checkbox"/>	<input type="checkbox"/> rejected for life insurance
<input type="checkbox"/>	<input type="checkbox"/> draining ear	<input type="checkbox"/>	<input type="checkbox"/> hepatitis B	<input type="checkbox"/>	<input type="checkbox"/> second job
<input type="checkbox"/>	<input type="checkbox"/> ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/> hepatitis C	<input type="checkbox"/>	<input type="checkbox"/> medically rejected
<input type="checkbox"/>	<input type="checkbox"/> ruptured ear drum	<input type="checkbox"/>	<input type="checkbox"/> diabetes/frequent boils	<input type="checkbox"/>	for employment
<input type="checkbox"/>	<input type="checkbox"/> hearing aid	<input type="checkbox"/>	<input type="checkbox"/> pancreas disease	<input type="checkbox"/>	for females only
<input type="checkbox"/>	<input type="checkbox"/> hay fever/allergies	<input type="checkbox"/>	<input type="checkbox"/> thyroid disease	<input type="checkbox"/>	<input type="checkbox"/> gynecological surgery
<input type="checkbox"/>	<input type="checkbox"/> frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/> weight gain	<input type="checkbox"/>	for males only
<input type="checkbox"/>	<input type="checkbox"/> sinus trouble	<input type="checkbox"/>	<input type="checkbox"/> weight loss	<input type="checkbox"/>	<input type="checkbox"/> prostate disease
<input type="checkbox"/>	<input type="checkbox"/> tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/> blood in stools		
<input type="checkbox"/>	<input type="checkbox"/> Do you have any abnormal or decreased sensation, numbness, tingling in the fingers/hands/wrists/forearms?				
<input type="checkbox"/>	<input type="checkbox"/> Are you presently under the care of a physician?				

List any hobbies: _____

WRITE ANY EXPLAINING REMARKS HERE:

Laboratory Animal Exposure History

- _____ Animal Protocol number(s) for this OHP enrollment
- Yes No Have you ever worked with laboratory animals?
- _____ (months) How many months you have worked with laboratory animals?
- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Rabbits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Guinea Pigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Old World Monkeys (Baboon, Macaque, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
New World Monkeys (Squirrel, Marmoset, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cattle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hamsters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Gerbils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prairie Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sheep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Goats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Swine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

If other, please specify: _____

- 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) _____
- Yes No Have you ever had any problems working around animals?
If yes, please explain: _____
- Yes No Do you currently experience problems working around animals?
If yes, please explain: _____
- 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) _____
- Do you use or wear any of the following items when working with animals?
 Protective Eye Glasses Yes Sometimes No
 Mask/Respirator Yes Sometimes No
 Lab Coat Yes Sometimes No
 Gloves Yes Sometimes No
- Are any agents of the following hazardous groups used in these animals?
 Infectious Teratogenic/Carcinogenic Radioactive Other: _____
 Please list if checked: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Type): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Certain medical conditions, such as immunosuppression and pregnancy, increase your risk of potential health problems working with pathogens, recombinant DNA, and/or animals.

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 medications 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. _____

Other comments

24. _____

Attestation and Signature

There may be increased occupational health risks associated with your job if situations change. At any time after completing this questionnaire,

if you become pregnant or if you start planning to become pregnant

or

if you become aware of a change in your health status

or

if the species of animal that you are exposed to at work changes

you are strongly encouraged to contact Employee Health to receive occupational health counseling, and/or evaluation.

Yes No **I have been informed about the Saint Louis University Occupational Health Program**

Yes No **I have had the opportunity to read the document "Safe Handling of Laboratory Animals."**

The above information is accurate and completed to the best of my knowledge.

Signature: _____ Date: _____

"

(Print Name)

"

"

"

"

Instructions to Submit

Return completed form to Employee Health. It is best to use our secure confidential fax: 314-268-56; 2. You can keep the original for your own records after you check the fax confirmation from your machine. Alternatively, the form can be interoffice mailed to Employee Health. It is still recommended that you keep a copy for your own records.

Saint Louis University
Occupational Health Program for Laboratory and Animal Research

MEDICAL SERVICES DECLINATION FORM

Only Complete and Sign This Form if You Are Declining Medical Services in the Saint Louis University
Occupational Health Program for Laboratory and Animal Research

The University and applicable research compliance committees (IACUC, IBC; RSC) must be assured that you are aware of the potential hazards associated with having contact with pathogens, recombinant DNA, and/or laboratory animals. Per University policy (RC-006), University personnel exposed to these hazards are required to participate in the Occupational Health Program for Laboratory and Animal Research (OHP). Persons required to participate in the OHP may decline the medical services component of the program. If you choose to decline the medical services, you are required to agree to the following:

1. I have been informed about the real and potential hazards associated with working with pathogens, recombinant DNA, and/or laboratory animals.
2. I attest that: (Check one)
 - I work with laboratory animals under Animal Use Protocol # _____;
AND I have been informed of the Saint Louis University Occupational Health Program;
AND I have had the opportunity to read the document "Safe Handling of Laboratory Animals."
 - I do not work with laboratory animals.
3. I knowingly decline the medical services offered in the Saint Louis University Occupational Health Program for Laboratory and Animal Research. I understand declining medical services could lead to, among other things, increased risk for health complications, inability to receive reimbursable care, and the need to secure my own alternate care provider for occupational health services.
4. I realize that declining the medical services of the Occupational Health Program may preclude me from some positions that require evaluation and preventative medical care.

IN SIGNING THIS FORM, I ACKNOWLEDGE AND REPRESENT THAT I have read the above Agreement, that I understand all its provisions, and I sign it voluntarily as my own free act and deed. I warrant that no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made.

_____ Date	_____ OHP Participant (print)	_____ OHP Participant (signature)
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If Participant is Under 18 Years of Age

_____ Date	_____ Parent/Legal Guardian (print)	_____ Parent/Legal Guardian (signature)
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Last Four Digits of Social Security#: XXX-XX- ____ - ____

Date of Birth _____ Contact Phone Number: (____) ____ - _____

Email Address: _____

Instructions to Submit: Return completed form to Employee Health. It is best to use the secure confidential fax: 314-268-56; 2. You can keep the original for your own records after you check the fax confirmation from your machine. Alternatively, the form can be interoffice mailed to Employee Health. It is still recommended that you keep a copy for your own records.