APPENDIX C: *Please complete this form, along with Appendix B (Occupational Health Risk Assessment Questionnaire). To maintain confidentiality, bring this form in a sealed envelope or mail to the Office of Safety, Stop 9031. The Office of Safety will mail or will give all forms to – Altru Occupational Health (Employer Health Solutions) for proper review.*

University of North Dakota Office of Safety
Medical Surveillance Questionnaire

To maintain your confidentiality, your PI/supervisor must not look at or review your answers.

INSTRUCTIONS: Employees/Students/Volunteers working with research animals or entering a vivarium are required to complete this questionnaire to identify applicable health and safety recommendations. The purpose of the following questions is to determine if you have any special health needs to work safely with animals. Based on your answers, medical recommendations will be provided to reduce risk of undesirable health effects and may include wearing additional personal protective equipment or modifying work procedures. In some cases, further medical evaluation may be indicated at Altru Occupational Health (Employer Health Solutions).

This form will be reviewed by a health care professional and kept in your confidential medical record at Altru.

Employee/Student Name: _____ Date of Birth: _____

UND ID#: _____ ☐ **Male** ☐ **Female** ☐ **Other _____** ☐ **Prefer not to answer**

UND Department: _____ Job Title: _____

Local Address: _____ Phone: _____

Supervisor: _____ Species to be handled: _____

UND OCCUPATIONAL HEALTH QUESTIONNAIRE (Your PI/Supervisor should not see this page)

1. Have you received a Tetanus vaccine? ☐ Yes ☐ No ☐ Unsure
   a. If yes, what is the date of your last Tetanus vaccination? _____
2. If you will be working with human blood/tissues/cells/cell lines in animals, have you received a Hepatitis B vaccination series? ☐ Yes ☐ No ☐ Unsure
   a. If yes, please list vaccination dates: 1 _____ 2 _____ 3 _____
   b. List year of vaccination: _____
3. Have you completed a HepB titer test? ☐ Yes ☐ No
   a. If yes, Titer result and date: _____

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Do you have any of the following medical conditions? **Yes** **No**

Allergy and Respiratory System Health History

- Asthma or other chronic respiratory disease ☐ ☐
- Skin conditions (such as eczema, psoriasis, dermatitis) ☐ ☐
- Allergic skin reactions (such as hives, rash, itching) ☐ ☐
  If yes, please explain: _____
- Known or suspected animal allergies ☐ ☐

Indicate any animal-related reaction(s):

☐ Runny/stuffy nose ☐ Itching eyes ☐ Sneezing ☐ Coughing
☐ Wheezing ☐ Chest tightness ☐ Shortness of breath ☐ Hives
☐ Skin rash ☐ Throat swelling ☐ Other _____

- Known or suspected allergies to chemicals, latex, food, or environment ☐ ☐
  If yes, please list: _____

If yes to <u>any of the above conditions</u>, list any treatment you receive to relieve your symptoms:

_____

_____

- Are you currently using respiratory protection or mask? ☐ ☐
  If yes, list type of respirator/mask you are using: _____
- Have you been fit-tested? ☐ ☐
  If yes, when was the last fitting? _____

Immune/Metabolic System Health History

- Chronic health conditions such as diabetes ☐ ☐
- Kidney or liver disease ☐ ☐
- Valvular heart disease ☐ ☐
- Seizures ☐ ☐
- History of spleen problems or absence of spleen ☐ ☐
- Pregnant or planning to become pregnant ☐ ☐
- Immune system deficiencies or other limitations to your ability to fight off disease or infection ☐ ☐
  (for example: cancer, lupus, organ transplant, HIV infection, chronic infections)
  If yes, please list: _____
- Current medication or treatment that may suppress your immune system ☐ ☐
  (for example: high-dose steroids, prednisone, cancer therapy, radiation therapy)
  If yes, please list: _____

Physical Health History

- Vision or hearing problems ☐ ☐
- Musculoskeletal disorder ☐ ☐
- Carpal tunnel syndrome or repetitive motion injury ☐ ☐
- Chronic back or joint pain ☐ ☐
  If yes to any of the above physical concerns, please explain: _____

Do you have any health or workplace concerns not covered by this questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the Occupational Health staff or your primary care physician? ☐ Yes ☐ No

If yes, contact Altru Occupational Health (Employer Health Solutions) at 701.780.1947 to follow-up with this health assessment.

By signature, I certify that the information provided is accurate to the best of my knowledge.

_____ _____

Participant Signature Date