**HEALTH HISTORY & ASSESSMENT**

**RESEARCH INTEGRITY & COMPLIANCE**

Complete Pages 1-5 to the Best of Your Ability and **Return in a Sealed Envelope Marked “Confidential”** by Mail to:

Occupational Health Service, Florida Hospital Carrollwood 7001 N. Dale Mabry Hwy, Ste. 5, Tampa, FL 33614 (813)558-8095 Fax (813)558-8096

|  |  |
| --- | --- |
| **Name:** | **Birthdate:** |
| **Principal Investigator:** | **Phone:** |



**Occupational Health-Related Medical History (complete this section only if you elect to not reveal your medical history)**

I understand that occupational health care services are required for employees whose duties involve possible exposure(s) to infectious agents that need biosafety level 3 or greater containment**,** unvaccinated or uncharacterized carnivores, pregnant sheep, goats, or cattle, or nonhuman primates. **I elect not to reveal or discuss my medical history, exposures away from work, exposures at work, health related symptoms, or provide any additional information.** If so, **STOP HERE,** sign below and submitthispage only to the above address.

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Signature of Employee Date



1. **OCCUPATIONAL HEALTH-RELATED MEDICAL HISTORY**

If you elect to reveal or discuss your medical history, exposures at and/or away from work, and health related symptoms, or provide any additional information, **complete and return the following pages to the above address.**

**A.1. Are you aware that you have ever had, or now have any of the following.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Measles |  |  | Mumps |  |  | Chicken Pox |  |  |
| Asthma |  |  | Allergies |  |  | Hay Fever |  |  |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Glaucoma |  |  | Stroke and/or Paralysis |  |  | High Blood Pressure |  |  |
| Chronic Rash |  |  | Nerve Problems |  |  | Diabetes |  |  |
| Rheumatic Fever |  |  | Arthritis |  |  | Stomach Ulcers |  |  |
| Heart Disease |  |  | Hepatitis/jaundice |  |  | Immunosuppression |  |  |
| Cirrhosis |  |  | Cancer |  |  | Chronic Fatigue Syndrome |  |  |
| Anemia |  |  | Diverticulitis |  |  | Asthma |  |  |
| Angina |  |  | Epilepsy |  |  | Pancreatitis |  |  |
| Gallstones |  |  | Tuberculosis |  |  | Pneumonia |  |  |
| Hayfever |  |  | Kidney Stones |  |  | Bronchitis |  |  |
| Splenectomy |  |  | Pleurisy |  |  | Emphysema |  |  |
| Thyroid disease |  |  | Nervous Breakdown |  |  | Colitis |  |  |
| Depression |  |  | Gout |  |  |  |  |  |
| Eczema |  |  | Multiple Chemical Sensitivities |  |  |  |  |  |

Additional comments regarding a “Yes” response indicated above, or information regarding **any other illness or disorder** not listed above can be provided in the box below.

A.2. If you are aware of a member of your family having one or more of the conditions listed above, please indicate the relation below, their age when first ill, the type of illness or condition, and whether they are now living or deceased.

|  |  |  |  |
| --- | --- | --- | --- |
| **Relation** | **Age** | **Illness or Condition** | **Living or Deceased** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**A.3. If you are aware of your vaccination history, indicate below the date you were vaccinated.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Date** |  | **Date** |  | **Date** |
| Smallpox |  | Polio |  | Influenza |  |
| Measles |  | Mumps |  | Rubella |  |
| Pneumovax |  | Anthrax |  | Yellow Fever |  |
| Hepatitis B |  | Hepatitis A |  | Tetanus |  |

**A.4. If you have been seen by a physician in the past year, indicate below the reason.**

**A.5. If you have ever been hospitalized, indicate below the date and reason.**

**A.6. If you have ever had a major injury (e.g., of the head, neck, back, chest, lung, or eye, or bone fracture(s), or an automobile injury), indicate below the date and type of major injury.**

**A.7. If you have ever had a blood transfusion, indicate below the date and reason for the transfusion.**

**A.8. If you are now taking, or have taken any medication (e.g., prescriptions, herbal products, supplements, vitamins) in the past six months, list these below.**

**A.9. If you have ever been seen by an allergist, or tested for allergies, or are allergic to any medication, food, or environmental allergens, indicate below and list the allergen, if known, and the type of reaction you experience.**

**B. OCCUPATIONAL HEALTH-RELATED EXPOSURES AWAY FROM WORK**

**B.1. If you have ever used tobacco products (e.g., cigarette, cigar, pipe, smokeless), or would like us to know your history of alcohol or illicit substance use, indicate below which products or substances and when these were used.**

**B.2. If you have contact with animal(s) at home, indicate below what animal(s) and whether they are allowed into the home.**

**B.3. If you have hobbies or leisure activities at home that may expose you to chemicals, fumes, loud noise, gases, dust (e.g., spray painting, furniture stripping, pool maintenance, fertilizer spreading), describe these below.**

**B.4. Indicate below the type of construction your home is (e.g., concrete block, brick, wood-frame, trailer), whether it is air-conditioned, whether the AC has a special filter system, the type of floor covering(s) on your home (e.g., carpet, tile, wood, terrazzo), whether a roof leak or flood has ever soaked the floor, walls, or ceilings, and whether there is any evidence of active mold growth in your home.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Construction** | **AC** | **Special Air Filters** | **Floor Covering(s)** | **Leak or Flood** | **Mold Growth** |
|  |  |  |  |  |  |

B.5. If you are an employee or volunteer at another facility outside of USF where you are exposed to animals or chemicals on a regular basis, describe this activity below.

C. OCCUPATIONAL HEALTH-RELATED EXPOSURES AT WORK

C.1. Check here if certified by the IACUC, in accordance with SOP 013 entitled “Employee Orientation and Training”, which is recorded on either form CMDC 101 entitled “Orientation of Research Staff” or CMDC 102 entitled “Orientation of Animal Care Staff”, as appropriate.

C.2. Check here if you are familiar with the safe practices and procedures outlined in SOP 905 entitled “Health, Hygiene, and Lab Attire”, and SOP 1008 entitled “Use of Personal Protective Equipment”.

C.3. Check here if you are working with nonhuman primates and are familiar with SOP 603 entitled “Protective Clothing When Working with Nonhuman Primates”, and SOP 605 entitled “Nonhuman Primate Cage Cleaning”.

C.4. Check here if you assist with animal husbandry and the safe use of chemicals and equipment to clean and sanitize surfaces and equipment as outlined in SOP 016 entitled “Animal Room Preparation”, SOP 100 entitled “Rabbit Husbandry”, SOP 200 entitled “Cat Husbandry”, SOP 300 entitled “Dog Husbandry”, SOP 400 entitled “Rodent Husbandry”, SOP 500 entitled “Avian Husbandry”, SOP 700 entitled “Livestock Husbandry”, and/or in SOP 800 entitled “Aquatic Vertebrate Room Duties”.

C.5. Check here if you assist with cage wash and the safe use of chemicals and equipment to clean and sanitize caging and equipment as outlined in SOP 1001 entitled “Use of Acid Scale Remover”, SOP 1002 entitled “Monitoring Autoclave Sterilization”, SOP 1003 entitled “Cagewash Detergents”, and in SOP 1005 entitled “Cagewash Operation”, and understand that hearing protection is required in these areas.

C.6. Indicate below by checking next to the job descriptor most representative of your work-related duties, by checking next to the species of animals you come into contact with, by checking next to the types of activities you assist with, by writing the approximate hours in an average eight (8) hour day each work-related activity is performed for all species combined, and describe any special health and safety considerations regarding your work.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Job Descriptor** | | **Species** | | **Activities** | | **Hrs/Day** | **Special Considerations** |
| Principal Investigator or Research Personnel |  | Mice |  | Observation & Records |  |  |  |
| Rat |  | Handling & Holding |  |  |  |
| Animal Care Technician |  | Rabbit |  | Husbandry & Care |  |  |  |
| Pig |  | Animal Room Housekeeping |  |  |  |
| Cage Wash Technician |  | Cat |  | Research Techniques |  |  |  |
| Dog |  | Substance Administration |  |  |  |
| Clinical Veterinarian |  | Sheep |  | Anesthesia & Surgery |  |  |  |
| Goat |  | Necropsy & Dissection |  |  |  |
| Administrator/Manager |  | Avian |  | Cage Wash & Autoclaving |  |  |  |
| Aquatic |  | Shipping & Receiving |  |  |  |
| Other (Physical plant, building service, IACUC personnel, etc.) |  | NHP |  | Housekeeping (non-animal areas) |  |  |  |
| Other |  | Facility Maintenance |  |  |  |

**D. OCCUPATIONAL HEALTH-RELATED SYMPTOMS**

**D.1. Indicate below if you have experienced any health related problems while at work, when they began, the specific symptoms you have experienced, what time of day you most notice them, if they improve when you are away from work, whether a specific work activity or task aggravates the symptoms, and whether you currently continue to experience this health related problem.**

**D.2. Indicate below if you have experienced frequent coughing, or coughing that produces sputum or mucous or blood, or a wheezing, whistling, or tightness in your chest, or a shortness of breath, or a chest cold or pneumonia, by describing the respiratory symptom, when and for how long it occurred, and whether you were seen by a physician for this condition.**

**D.3. Are you aware that you have experienced, or are now experiencing any of the following signs or symptoms.** (check any and all that apply)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| Change in Body Weight |  |  | Diminished Hearing |  |  | Frequent Indigestion |  |  |
| Recurring Skin Condition |  |  | Ear Ache |  |  | Frequent Nausea |  |  |
| Change in Skin Color |  |  | Discharge from Ear |  |  | Diarrhea |  |  |
| Rash |  |  | Buzzing or Ringing Sound |  |  | Abdominal Discomfort |  |  |
| Hives |  |  | Stuffy Nose |  |  | Constipation |  |  |
| New Eye Glasses |  |  | Runny Nose |  |  | Muscle Aches |  |  |
| Diminished Vision |  |  | Itchy Nose |  |  | Joint Pain |  |  |
| Eye Pain |  |  | Tender Sinus |  |  | Back Pain |  |  |
| Burning, Itching, Tearing Eyes |  |  | Excess or Decreased Salivation |  |  | Frequent, Painful or Bloody Urination |  |  |
| Troublesome Contacts |  |  | Raspy Voice |  |  | Dizziness |  |  |
| Mucous in Eyes |  |  | Sore Throat |  |  | Nervousness |  |  |
| Lymph Node Swelling |  |  | Chest Pain |  |  | Irritability |  |  |
| Neck Pain |  |  | Rapid or Slow Heart Beat |  |  | Headaches |  |  |
| Neck Muscle Spasms |  |  | Leg Swelling |  |  | Fatigue |  |  |
| Irregular Menstruation |  |  | Pause in Heartbeat |  |  | Faintness |  |  |

Additional comments regarding a “Yes” response indicated above, or information regarding **any other sign or symptom** not listed above can be provided in the box below.

**E. ADDITIONAL INFORMATION**