THE UNIVERSITY OF VERMONT

Occupational Health and Safety Program
Questionnaire for Personnel Working with Animals

The Occupational Health and Safety Program is a required part of the overall animal care and use program. UVM employees and students who work with animals must be offered occupational health monitoring services prior to working with animals. The goal of the Program is to maintain a safe and healthy workforce and is offered free of charge. Participation is simple and involves completion of this medical questionnaire every three years.

The UVM Department of Risk Management & Safety (RMS) has contracted with two outside Medical Facilities to review these questionnaires and provide occupational health monitoring services for employees. These facilities are: Champlain Medical (150 Kennedy Dr, South Burlington, VT 05403) and Concentra (57 Fayette Road, Unit 1, South Burlington, VT 05403). Eligible UVM students completing this questionnaire will have the questionnaire forwarded to the UVM Student Health Services (425 Pearl St, Burlington, VT 05401) for review.

The completed questionnaire is maintained only at the Medical Facility responsible for reviewing the form; RMS does not maintain a copy. **Employees** found to have risk factors that require further medical evaluation will be contacted by a member of RMS to schedule an appointment at the appropriate facility. **Students** will be contacted by the Student Health Services provider for clarification or further medical evaluation. An employee's supervisor may be contacted if repeated attempts to contact the employee regarding this questionnaire are unsuccessful.

Completion Instructions:
All personnel must fill out Section 1. If you choose to participate in the Program, please fill out all applicable sections of this questionnaire. If you choose to decline participation, please skip to the last page and sign on the appropriate line.

Submission Instructions:
Option 1 - Scan the completed questionnaire into PDF and email it to ohealth@uvm.edu (We cannot guarantee confidentiality of the information submitted via email. However, only 2 staff members in RMS have access to this account and only will confirm the questionnaire is complete before forwarding to the appropriate medical facility.)

Option 2 - Place completed questionnaire in a sealed envelope, legibly write your name and "CONFIDENTIAL-OCC HEALTH FORM". Forward the sealed envelope by campus mail to Risk Management at the address below:

Amy Kutchukian
Risk Management & Safety
004 Rowell
Burlington, VT 05405

You must sign the last page to accept or decline participation in the Occupational Health and Safety Program. You will be contacted by RMS staff if this is section is not complete.

Section 1: Personal Information – Required

Today's Date: _____ Student ID# (if applicable) _____
Name: _____ Job Title: _____
Date of Birth: _____ Age: _____
Work Phone: _____ Alternative Phone: _____
Email Address: _____
Campus Work Address: _____
If a healthcare provider needs to contact you, when is the best time to call? _____
Supervisor Name: _____ Supervisor Phone: _____
Supervisor Email: _____
PI/Laboratory: _____ Protocol #: _____

If you choose to participate in the Occupational Health Program, please fill out the reminder of the questionnaire. If you choose to decline participation, skip ahead to Page 8.

Section 2: Medical Background

1. What is your country of origin?_____
2. How many years did you reside there?_____
3. What is your height?_____ 4. What is your weight?_____

Section 3: Health History

1. Has your health changed in any way since you completed the last Animal Handler questionnaire? Y___N___N/A___
   If yes, how _____

2. Do you now have or have you ever had any of the following:

Y___N___Diabetes	Y___N___Allergies to pollen, food, etc.
Y___N___Seizure disorder	Y___N___Muscle or bone problems
Y___N___Skin rashes	Y___N___Repeated episodes of diarrhea
Y___N___Glove allergies/rashes	Y___N___Drug or alcohol dependency
Y___N___Diagnosis of latex allergy	Y___N___Have you ever had measles
Y___N___Hernia	Y___N___Measles vaccine

   Y___N___Problems with visual acuity/hearing ability
   Y___N___Immune system suppression **If **yes,** the cause of the suppression was/is:
   _____

3. For women: Are you currently pregnant or planning to be pregnant in the coming year? Y___N___

4. When was your last tetanus vaccination?_____

5. What was the date and result of your last TB test?_____

6. Do you have any current health problems **not** listed above that affect your work with animals? Y___N___

   If "yes"**, please explain_____

7. Are you aware of the health risks associated with your job? Y___N___

8. Do you currently have any of the following vision problems?
   a) Wear contact lenses Y___N___
   b) Wear glasses Y___N___
   c) Color blind Y___N___
   d) Any other eye or vision problems Y___N___

9. Have you ever had an injury to your ears, including a broken ear drum? Y___N___

10. Do you currently have any of the following hearing problems?
    a) Difficulty hearing Y___N___
    b) Wear a hearing aid Y___N___
    c) Any other hearing or ear problems Y___N___

11. Do you currently have any of the following musculoskeletal problems?
    a) Weakness in any of your arms, hands, legs or feet Y___N___

b) Back pain Y___N___
c) Difficulty fully moving your arms and/or legs Y___N___
d) Pain or stiffness when you lean forward or backward at the waist Y___N___
e) Difficulty fully moving your head up or down Y___N___
f) Difficulty fully moving your head side to side Y___N___
g) Difficulty bending at your knees Y___N___
h) Difficulty squatting to the ground Y___N___
i) Climbing a flight of stairs or a ladder Y___N___

12. Do you work with patients? Y___N___

13. Do you currently smoke tobacco or have you smoked tobacco in the last month? Y___N___

Section 4: Animal Contact History

1. What animals will you be working with? _____

2. What chemicals, biohazards, pharmaceuticals or radioisotopes will you be working with?

_____

3. Do you have a history of hay fever, asthma, allergic skin problems or eczema? Y___N___
To what are you allergic? _____

4. Is there a family history of hay fever, asthma, allergic skin problems or eczema? Y___N___

5. Have you been vaccinated against rabies? Y___N___
If so, when was the last titer?_____

6. Have you worked with or had regular contact with primates? Y___N___
If so, any old world primates? Y____N____

7. Do you have sneezing spells, runny or stuffy nose, watery or itchy eyes, coughing, wheezing or shortness of breath after working with laboratory animals or their cages Y____N___

If "**yes**", which of the following species cause any of the problems?

Guinea pig	Y___N___	Rabbit	Y___N___
Hamster	Y___N___	Goat	Y___N___
Dog	Y___N___	Horse	Y___N___
Cat	Y___N___	Sheep	Y____N_
Mouse	Y___N___	Bedding	Y___N___
Rat	Y___N___	Other	Y___N___

If "**yes**", please describe symptoms: _____

8. In general, how frequently are you bothered by the following symptoms?

Watery, itchy eyes	Not troubled _____	Once/Week or more _____	Almost daily _____
Runny or stuffy nose	Not troubled _____	Once/Week or more _____	Almost daily _____
Sneezing spells	Not troubled _____	Once/Week or more _____	Almost daily _____
Frequent cough	Not troubled _____	Once/Week or more _____	Almost daily _____
Wheezing in chest	Not troubled _____	Once/Week or more _____	Almost daily _____

9. Do you have any house pets? Y___ N____
If "**yes**", what type of animals?_____

Please answer the following only if you work with sheep, cows or goats. Otherwise skip to next section

1. Have you ever worked with sheep, cows or goats before? Y___N___
   When? _____

2. How frequently do you work with sheep, cows or goats?

   Daily___ Once/week___ Once/month___

3. Do you directly handle birth products of sheep, cows or goats? Y___N___
   If yes, how frequently? _____

4. Do you live on a farm or work with animals at home? Y___N___
   If "**yes**", which animals? _____

If you answered YES to questions 3, 7, or 8 in the Animal Contact History section, you MUST complete the remainder of the questionnaire. Otherwise, you may skip to the General Consent page.

Section 5: Respiratory Health

1. Do you currently wear a respirator to perform any part of your job? Y___N___

   Check any/all that apply:

   Disposable___ ½ Face ___

   Full Face ___ PAPR ___

2. Have you ever worn a respirator? Y___N___

   If "**yes**", what type(s): _____

3. Have you ever had any of the following conditions?
   a) Seizures (fits) Y___N___
   b) Diabetes (sugar disease) Y___N___
   c) Allergic reactions that interfere with your breathing Y___N___
   d) Claustrophobia (fear of closed in places) Y___N___
   e) Trouble smelling odors Y___N___

4. Have you ever had any of the following pulmonary or lung problems?
   a) Asbestosis Y___N___
   b) Asthma Y___N___
   c) Chronic Bronchitis Y___N___
   d) Emphysema Y___N___
   e) Pneumonia Y___N___
   f) Tuberculosis Y___N___
   g) Silicosis Y___N___
   h) Pneumothorax (collapsed lung) Y___N___
   i) Lung cancer Y___N___
   j) Broken ribs Y___N___
   k) Any chest injuries or surgeries Y___N___
   l) Any other lung problem that you've been told about Y___N___

5. Do you currently have any of the following symptoms of pulmonary or lung illness?

a) Shortness of breath Y___N___
b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline Y___N___
c) Shortness of breath when walking with other people at an ordinary pace on level ground Y___N___
d) Have to stop for breath when walking at your own pace on level ground Y___N___
e) Shortness of breath when washing or dressing yourself Y___N___
f) Shortness of breath that interferes with your job Y___N___
g) Coughing that produces phlegm (thick sputum) Y___N___
h) Coughing that wakes you early in the morning Y___N___
i) Coughing that occurs mostly when you are lying down Y___N___
j) Coughing up blood in the mouth Y___N___
k) Wheezing Y___N___
l) Wheezing that interferes with your job Y___N___
m) Chest pain when you breathe deeply Y___N___
n) Any other symptoms that you think may be related to lung problems Y___N___

6. Have you ever had any of the following cardiovascular or heart problems?
a) Heart attack Y___N___
b) Stroke Y___N___
c) Angina Y___N___
d) Heart failure Y___N___
e) Swelling in your legs of feet (not caused by walking) Y___N___
f) Heart arrhythmia (heart beating irregularly) Y___N___
g) High blood pressure Y___N___
h) Any other heart problem that you've been told about Y___N___
If "**yes**", please explain:_____

7. Have you ever had any of the following cardiovascular or heart symptoms?
a) Frequent pain or tightness in your chest Y___N___
b) Pain or tightness in your chest during physical activity Y___N___
c) Pain or tightness in your chest that interferes with your job Y___N___
d) In the past two years, have you noticed your heart skipping or missing a beat Y___N___
e) Heartburn or indigestion that is not related to eating Y___N___
f) Any other symptoms that you think may be related to heart or circulation problems Y___N___
If "**yes**", please explain:_____

8. Do you currently take medication for any of the following problems?
a) Breathing or lung problems Y___N___
b) Heart trouble Y___N___
c) Blood pressure Y___N___
d) Seizures (fits) Y___N___

9. If you've used a respirator, have you ever had any of the following problems?
a) Never used a respirator_____skip to next question
b) Eye irritation Y___N___
c) Skin allergies or rashes Y___N___
d) Anxiety Y___N___
e) General weakness or fatigue Y___N___
f) Any other problem that interferes with your use of a respirator Y___N___
If "**yes**", please explain:_____

10. Do you have any muscle or skeletal problem that interferes with using a respirator? Y___N___

11. Would you like to talk to the health care professional who will review this questionnaire? Y___ N___

a) Have to stop for breath when walking at your own pace on level ground Y___N___
b) Shortness of breath when washing or dressing yourself Y___N___
c) Shortness of breath that interferes with your job Y___N___
d) Coughing that produces phlegm (thick sputum) Y___N___
e) Coughing that wakes you early in the morning Y___N___
f) Coughing that occurs mostly when you are lying down Y___N___
g) Coughing up blood in the mouth Y___N___
h) Wheezing Y___N___
i) Wheezing that interferes with your job Y___N___
j) Chest pain when you breathe deeply Y___N___
k) Any other symptoms that you think may be related to lung problems Y___N___

12. Have you ever had any of the following cardiovascular or heart problems?
a) Heart attack Y___N___
b) Stroke Y___N___
c) Angina Y___N___
d) Heart failure Y___N___
e) Swelling in your legs of feet (not caused by walking) Y___N___
f) Heart arrhythmia (heart beating irregularly) Y___N___
g) High blood pressure Y___N___
h) Any other heart problem that you've been told about Y___N___
If "**yes**", please explain:_____

13. Have you ever had any of the following cardiovascular or heart symptoms?
a) Frequent pain or tightness in your chest Y___N___
b) Pain or tightness in your chest during physical activity Y___N___
c) Pain or tightness in your chest that interferes with your job Y___N___
d) In the past two years, have you noticed your heart skipping or missing a beat Y___N___
e) Heartburn or indigestion that is not related to eating Y___N___
f) Any other symptoms that you think may be related to heart or circulation problems Y___N___
If "**yes**", please explain:_____

14. Do you currently take medication for any of the following problems?
a) Breathing or lung problems Y___N___
b) Heart trouble Y___N___
c) Blood pressure Y___N___
d) Seizures (fits) Y___N___

15. If you've used a respirator, have you ever had any of the following problems?
a) Never used a respirator_____skip to next question
b) Eye irritation Y___N___
c) Skin allergies or rashes Y___N___
d) Anxiety Y___N___
e) General weakness or fatigue Y___N___
f) Any other problem that interferes with your use of a respirator Y___N___
If "**yes**", please explain:_____

16. Do you have any muscle or skeletal problem that interferes with using a respirator? Y___N___

17. Would you like to talk to the health care professional who will review this questionnaire? Y__ _ N___

12 to 17 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

18. Have you ever lost vision in either eye (temporarily or permanently)? Y___N____

19. Do you currently have any of the following vision problems?
    a) Wear contact lenses Y___N____
    b) Wear glasses Y___N____
    c) Color blind Y___N____
    d) Any other eye or vision problem Y___N____

If "**yes**", please explain:_____

20. Have you ever had an injury to your ears, including broken eardrum? Y___N____

21. Do you currently have any of the following hearing problems?
    a) Difficulty hearing Y___N____
    b) Wear a hearing aid Y___N____
    c) Any other hearing or ear problem Y___N____

If "**yes**", please explain:_____

22. Have you ever had a back injury? Y___N____

23. Do you currently have any of the following musculoskeletal problems?
    a) Weakness in any of your arms, hands, legs or feet Y___N____
    b) Back pain Y___N____
    c) Difficulty fully moving your arms and/or legs Y___N____
    d) Pain or stiffness when you lean forward or backward at the waist Y___N____
    e) Difficulty fully moving your head up or down Y___N____
    f) Difficulty fully moving your head side to side Y___N____
    g) Difficulty bending at your knees Y___N____
    h) Difficulty squatting to the ground Y___N____
    i) Climbing a flight of stairs or a ladder carrying more than 25 lbs Y___N____
    j) Any other muscle or skeletal problems that interfere with using a respirator Y___N____

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Occupational Health and Safety Program
Questionnaire for Personnel Working with Animals
General Consent for Review and Release of Medical Information

I certify that the above statements are true, complete and correct to the best of my knowledge and belief.

I consent to review of this information by Champlain Medical, Concentra, or Student Health Services on behalf of the University of Vermont. I understand that this review is undertaken for my safety in the job environment and understand that I may be further contacted by Champlain Medical, Concentra, Student Health Services or a member of Risk Management & Safety either for clarifications or further evaluation. Further evaluation may include, but is not limited to, a physical examination, blood tests, an evaluation of lung function and other diagnostic tests as necessary. Costs for evaluation and testing will be covered by the University of Vermont.

Please sign on **ONE** of the lines below to either accept or decline participation in the Occupational Health and Safety program. *****Please do not sign both areas*****

To **ACCEPT** participation in the Occupational Health and Safety program, please sign below:

I further understand that this information and the results of subsequent tests/treatments that relate to my job and the performance of essential job functions or to student research activities may be released to my Supervisor.

Signature:_____

Printed Name:_____ Date Signed:_____

-- OR --

To **DECLINE** participation in the Occupational Health and Safety program, please sign below:

I understand that if I decline participation in the Occupational Health and Safety Program, my employment status or student research status might change to meet acceptable safety and wellbeing standards.

Signature:_____

Printed Name:_____ Date Signed:_____

Champlain Medical/Concentra/UVM Student Health Services Use Only:

Reviewed by:_____ Date:_____

Medically Cleared_____ Not Medically Cleared _____