

Health Review for Animal Handlers

Employees in certain job categories are required to undergo a health review at the beginning of their job and at periodic intervals. This policy includes DU personnel who work with animals. Please complete this form and submit it to DU's Office of Environmental Health and Safety, Mary Reed Building, Room 418.

This information is confidential.

First Name:

Last Name:

University of Denver ID:

Date of Birth:

Home Phone:

Work Phone:

Email Address:

Cell Phone/Pager:

Home Address:

City:

State:

Zip Code:

Supervisor Name:

Supervisor Phone:

Dept/Address:

Job Title:

I certify that the information below is true, complete, and correct to the best of my knowledge and belief. I understand that the Director of EHS may view the completed questionnaire.

I Agree

Health History

1. Do you now have or have you ever had any of the following: Yes No

a. Diabetes?

| | | |
|--|--------------------------|--------------------------|
| b. Seizure disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Skin rashes? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Glove allergies/rashes? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diagnosis of latex allergy? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Hernias or herniated disc? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Allergies to pollen, food, animals, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Muscle or bone problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Repeated episodes of diarrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Drug or alcohol dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Have you ever had measles? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Measles vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Problems with visual acuity/ hearing ability? | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Rabies vaccine series? | <input type="checkbox"/> | <input type="checkbox"/> |
| Year: | <input type="text"/> | |
| p. TB skin test? | <input type="checkbox"/> | <input type="checkbox"/> |
| Results: | <input type="text"/> | |
| Year: | <input type="text"/> | |
| q. Immune system suppression? | <input type="checkbox"/> | <input type="checkbox"/> |

If **yes** to any of the questions above, please explain:

2. Do you have a family history of hayfever, asthma, allergic skin problems or eczema? Yes No

3. When was your last tetanus vaccination?

4. What animals do you work with at the University of Denver?

5. Do you have any safety/health concerns about chemicals you are working with?

Yes No

If yes, please describe.

7. Have you ever been fit tested for a respirator to wear while working with lab animals?

Yes No

8. When working with animals, how often do you wear the following:

Never Sometimes Always

| | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|
| a. Gloves | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Gown | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Surgical Mask | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Disposable Respirator | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Non-disposable Respirator | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Goggles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Face shield | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

9. How frequently do you wash your hands after handling animals/animal products?

Never Sometimes
 Always

10. If you have completed this questionnaire before, have you developed any of the following since you last filled out this health review:

| | | |
|---------------------------|------------------------------|-----------------------------|
| a. Hayfever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Allergic skin problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

11. Have you been evaluated for animal related health problems?

Yes No

If yes, please list:

12. Do you have any work restrictions?

Yes No

If yes, please explain:

13. 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/bedding? *If no go to question #15.*

Yes No

If yes, please answer the following:

a. When did the symptoms begin? (month & year)

b. Are the symptoms worse than one year ago?

Yes No

c. Are you taking medications to control symptoms?

Yes No

If yes, please list:

d. Check all of the following that cause any of your symptoms.

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Guinea pig | <input type="checkbox"/> Rabbit |
| <input type="checkbox"/> Hamster | <input type="checkbox"/> Goat |
| <input type="checkbox"/> Dog | <input type="checkbox"/> Birds |
| <input type="checkbox"/> Cat | <input type="checkbox"/> Sheep |
| <input type="checkbox"/> Mouse | <input type="checkbox"/> Bedding |
| <input type="checkbox"/> Rat | <input type="checkbox"/> Other: <input type="text"/> |

14. In general, how frequently are you bothered by the following symptoms related to work with animals or their cages?

Not troubled Once/month Once/week Almost daily

| | | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Skin rash or hives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Watery, itchy eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Runny or stuffy nose | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Sneezing spells | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Frequent cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Wheezing in chest | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

15. Do you have any house pets?

Yes No

If yes, what type(s) of animals?

16. Have you had any on-the-job injuries or exposures you have not reported?

Yes No

If yes, please describe:

17. Do you live on a farm or work with animals at home?

Yes No

If yes, which animals?