

**UNIVERSITY OF ALABAMA ANIMAL CARE AND USE PROGRAM (UAACUP)  
HEALTH HISTORY MEDICAL EVALUATION FORM**

An important element of the UAACUP Occupational Health and Safety Program is medical evaluation and preventive medicine. A component of the medical evaluation is a health history oriented toward the environment in which animals are used in research. Your answers will direct the health team in determining if any special training, accommodation or diagnostic testing may be necessary. A component of preventive medicine is in providing immunization. Specific immunizations will depend upon specific exposures. Return the completed form to the Director of the Animal Care Facility.

**Please fill out completely (Print or type)**

\_\_\_\_\_  
Name (Last, First, Middle Initial) Date of Birth

\_\_\_\_\_  
Position

\_\_\_\_\_  
Current Address

\_\_\_\_\_  
City State Zip Sex

\_\_\_\_\_  
Home Telephone Campus Telephone SS#

\_\_\_\_\_  
Family Physician Name Telephone

\_\_\_\_\_  
In case of an emergency contact (name, address, phone)

**PART 1: EXPOSURE TO ANIMALS**

Do you have any indoor pets? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you work with or come in contact with any animals on a routine basis? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes to either question, which animal and for how long?

<b>Animal</b>	<b>1-2 years</b>	<b>2-3 years</b>	<b>3-4 years</b>	<b>Over 4 years</b>
Dogs				
Cats				
Birds				
Rodents				
Reptiles				
Other (type)				

**PART 2: SPECIAL NEEDS:**

Answer the following questions as they relate to your anticipated work within the Animal Care Facility

1. Are you or will you be exposed to noise levels at 8 hour time-weighted average sound level of 85 decibels (you cannot be heard by another using a normal tone of voice)?

Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

2. Will you or do you perform functions that will involve aerosolization of toxic chemicals?

Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

3. Will you or are you required to lift animals, supplies or equipment exceeding 50 pounds?

Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

4. Are you or will you be engaged in a repetitive movement activity?

Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

5. Do you have a previous illness/injury that will require special accommodations?

Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

### PART 3: HEALTH HISTORY AS IT RELATES TO EXPOSURE TO RESEARCH

Direct any questions regarding this form or how your health history might be affected by your work at UA, to your personal physician.

#### ALLERGIES

ARE YOU WORKING OR HAVE YOU WORKED WITH LABORATORY ANIMALS?

Animal	Yes, current	Yes, past	No	Approx. contact hrs./day & past yrs. of experience
Rats				
Mice				
Rabbits				
Guinea Pigs				
Monkeys				
Cattle				
Dogs				
Cats				
Swine				
Hamsters				
Birds				
Other				

Do you use or wear any of the following items when working with animals?

PPE	Yes	No
Protective Eye Wear		
Face Shield		
Mask/Respirator		
Lab Coat		
Shoe Covers		
Gloves		

#### ALLERGIC SYMPTOMS

Do you believe that you are allergic to any of these animals? Yes \_\_\_\_\_ No \_\_\_\_\_

Check all that apply:

Rats	Mice	Rabbits	Dogs
Cats	Monkeys	Cattle	Guinea Pigs
Swine	Birds	Hamsters	Reptiles
Other (specify)			

Do you regularly have any of the following symptoms? Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate if the symptom is present and the year of onset. Also check the location where symptoms are present.

Symptom	Yes/No Present	Year of Onset	At work	At home	On vacation
Cough					
Sputum production					
Shortness of breath					
Wheezing					
Chest tightness					
Asthma					
Nose congestion					
Runny nose					
Sneezing					
Itchy eyes					
Sinus problems					
Hay fever					
Frequent colds					
Hives					
Skin rash					
Swelling of eyes/lips					

Eczema					
Difficulty swallowing					

Were you ever told by a doctor that you had allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which allergy? \_\_\_\_\_

Have you ever been skin tested or had serological tests for allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, to which of the following substances were you determined to be allergic? Check all that apply.

Ragweed	Grass	Trees	Mold
Dust	Cats	Dogs	Rodents
Other (Specify)			

Have you ever received allergy (desensitization/immunotherapy) shots? Yes \_\_\_\_\_ No \_\_\_\_\_

**OTHER ALLERGIES**

Do you have a history of allergies to latex? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

Do you have a history of allergies to chemicals, such as formalin? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

If yes, specify \_\_\_\_\_

**ASTHMA**

Has a doctor ever said you have asthma? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when did your asthma start? \_\_\_\_\_ (year)

Are you currently taking medication (either over-the-counter or prescription) to control your asthma?

Yes \_\_\_\_\_ No \_\_\_\_\_

Do you regularly use "over-the-counter" (non-prescription) nose drops or nose sprays, e.g. Afrin, Neosynephrine?

Yes \_\_\_\_\_ No \_\_\_\_\_

**SMOKING**

Do you smoke tobacco products? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much per day? \_\_\_\_\_ How many years? \_\_\_\_\_

If not presently smoking, did you ever smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when did you stop smoking? \_\_\_\_\_ (year) How many years did you smoke? \_\_\_\_\_

**IMMUNIZATIONS**

Tetanus-diphtheria (dT) booster should be within the last 10 years. Most recent booster: \_\_\_\_\_ (date)

Most recent tuberculin testing: PPD Date/year \_\_\_\_\_ mm induration \_\_\_\_\_

Have you had a chest X-ray related to a positive PPD tuberculin test or BCG vaccination status?

If yes: Date/year \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ (Please attach copy of chest x-ray results)

Have you completed the Hepatitis B immunization series? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

List any other immunizations you have received other than childhood series:

Immunization	Year

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

