

ANIMAL EXPOSURE SURVEILLANCE QUESTIONNAIRE

Submission Instructions: Fax to Ellen Bibb at Occupational Health at 410 955-1617

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This form is completed at: Pre-placement Annual follow-up

GENERAL INFORMATION

Name: _____ Today's Date: ____/____/____

Last 4 Digits of Social Security#: _____ Badge ID: _____ JHED ID: _____

Date of Birth ____/____/____ Sex: Male Female

Race: White Black Asian Other (Specify) _____

Answer these questions about the job you are applying for or the job where you are currently working:

PI: _____ Department: _____

Departmental Address: Building: _____ Room: _____

Work Telephone Number: _____ E-mail Address: _____

Job Title: _____ Date the job starts: ____/____/____

Status: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Faculty | <input type="checkbox"/> Academic Staff | <input type="checkbox"/> Post-Doc Fellow |
| <input type="checkbox"/> Undergraduate Student | <input type="checkbox"/> Graduate Student | <input type="checkbox"/> Civil Service Staff |
| <input type="checkbox"/> Employee | <input type="checkbox"/> Other _____ | |

Occupation: (Check one)

- | | | |
|--|---|--|
| <input type="checkbox"/> Graduate Student | <input type="checkbox"/> Animal Care Worker/Handler | <input type="checkbox"/> Lab Technician |
| <input type="checkbox"/> Research/Teaching Personnel | <input type="checkbox"/> Veterinarian | <input type="checkbox"/> Veterinarian Technician |
| <input type="checkbox"/> Other _____ | | |

OCCUPATIONAL ANIMAL EXPOSURE HISTORY

1. Have you ever worked with laboratory animals? Yes No
2. How many months you have worked with laboratory animals? _____ (months)
3. Check the boxes below if you have been in contact with the following animals. Please specify contact hours/day, total duration (months), and months at Johns Hopkins.

ANIMAL	Previously	Currently	Never	Contact Hours/Day	Total Months	Months At JH
Rats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Rabbits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Guinea Pigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Old World Monkeys (Baboon, Macaque, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
New World Monkeys (Squirrel, Marmoset, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cattle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hamsters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Gerbils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prairie Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sheep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Goats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Swine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

If other, please specify: _____

4. Do you think that you are allergic to any of these animals? Yes No
 If yes, please check all that apply:
 Rats Mice Rabbits Guinea Pigs Monkeys Cattle
 Dogs Cats Hamsters Gerbils Prairie Dogs Dogs
 Sheep Goats Swine Other (specify) _____
5. Do you use or wear any of the following items when working with animals?
 Protective Eye Glasses Yes Sometimes No
 Mask/Respirator Yes Sometimes No
 Lab Coat Yes Sometimes No
 Gloves Yes Sometimes No
6. Have you ever contracted a disease from animals, or experienced an animal related injury (including bites, scratches, needle sticks, etc.)? Yes No
 If yes, please explain: _____
7. Are you involved with recombinant DNA technology or microorganisms that contain recombinant DNA?
 Yes No Unknown
 If yes, does the research involve techniques in which viable, recombinant DNA-containing microorganisms are used to infect animals that require Bio-safety level 2 or 3 containment? Yes No Unknown
 Explain: _____
8. Are any agents of the following hazardous groups used in these animals?
 Infectious Teratogenic/Carcinogenic Radioactive Other: _____
 Please list if checked: _____

HOME ENVIRONMENT INFORMATION

9. Do you have any indoor pets? Yes No
 If yes, which animals and for how long?
- | Animal | 1-2 Years | 2-3 Years | 3-4 Years | Over 4 Years |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Dogs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cats | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (Type): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
10. Please List Your Hobbies: _____
11. Do you smoke cigarettes? Yes No
 If yes, at what age did you start smoking? _____ (years old)
 How many years have you been smoking? _____
 How many cigarettes per day? _____
 If not presently smoking, did you ever smoke? Yes No
 If yes, what year did you stop smoking cigarettes? _____
 How many years did you smoke? _____
12. What type of fuel do you use at home?
 Cooking: Electricity Gas/propane Oil Wood Other _____
 Heating: Electricity Gas/propane Oil Wood Other _____
13. Do you have roaches in your home? Yes No
14. Do you have non-pet mice or other animals in your home? Yes No

MEDICAL HISTORY

15. Do you regularly have any of the following symptoms? Yes No
 If yes, please indicate the symptom and frequency of onset. Also check in what location or time period the symptom (s) is/are present:

Symptom	<u>ONSET</u>	<u>FREQUENCY</u>				<u>SYMPTOMS PRESENT</u>			
	Year Started	Weekly	Monthly	Yearly	Rarely	At Work	At Home	On Vacation	No Difference
Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Tightness	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colds	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in Swallowing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy Eyes	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose Congestion	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sputum Production	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Eyes or Lips	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Were you ever told by a doctor that you had allergies? Yes No
17. Have you ever been skin tested for allergies? Yes No
 If yes, what substances were you found to be allergic to or sensitized to?
 Ragweed Grass Trees Mold Mice
 Dust Cat Dog Other: _____
18. Have you ever received allergy (desensitization/immunotherapy) shots? Yes No
 If yes, what year did you receive the shots? _____
19. Has a doctor ever said you have asthma? Yes No
 If yes, what year did your asthma start? _____
 Are you currently taking medication (either over the counter or by prescription) to control your asthma?
 Yes No
 If yes, what medications are you on? _____
20. Has a doctor ever told you that you have a medical condition caused by your working conditions?
 Yes No
 If yes, what is the condition? _____
21. Do any of your blood relatives (grandparents, parents, brothers/sisters) have allergies or asthma?
 Yes No
22. Have you ever been treated for the following diseases?
 Yes No
 If yes, please check the illnesses:
- | | | |
|--|--|--|
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Severe Facial Acne | <input type="checkbox"/> Stress | <input type="checkbox"/> Recurrent Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur /Valve Disease |

- Cancer
- Seizures
- Loss of Consciousness
- Chronic Bronchitis
- Kidney Disease
- Arthritis
- Anxiety
- Irregular Heart Beat
- Chronic Back or Joint Pain
- Gastrointestinal Disorder
- High Blood Pressure
- Other _____

23. List prescribed and over the counter medications:

Name of Medication	Reason for taking	Last time taken

24. Have you ever had an occupational illness or injury? Yes No

If yes, when? _____

What happened? _____

25. Did this injury or illness cause:

- permanent change of position
- temporary assignment
- termination of a job

26. Did you ever receive workers' compensation? Yes No

IMMUNIZATIONS

27. Check the box and indicate date(s) of most recent vaccination or blood tests to document antibody status. Please approximate the date if you can't remember the exact date.

- Measles _____ Mumps _____ Rubella _____
- Hepatitis A _____ Hepatitis B _____ CMV _____
- Toxoplasmosis _____ 'Q' Fever _____ BCG _____
- Rabies _____ Vaccinia _____ Varicella _____
- (smallpox) _____ (chickenpox) _____

Date of last rabies Booster: _____ Date of last tetanus booster: _____

If not immunized for chickenpox, did you have chickenpox? Yes No

TUBERCULOSIS SCREENING

28. Date of last PPD skin test: _____ / _____ / _____ Positive Negative

If Positive, date of last chest x-ray: _____ / _____ / _____

If Positive, in past, are you having any of the following symptoms?

- Weight loss
- Shortness of breath
- Chronic Cough
- Bloody sputum
- Fever

FOR WOMEN ONLY

29. Are you pregnant? Yes No

30. Are you planning to be pregnant in the next year? Yes No

Comments: _____

Reviewed By: _____

Date: _____ / _____ / _____