ANIMAL EXPOSURE SURVEILLANCE QUESTIONNAIRE

Confidential - for Occupational Health Use Only

Instructions: Please complete the Questionnaire to the best of your ability. If you are unsure, or are uncomfortable answering any of the questions, please leave them blank.
Fax the completed Questionnaire to Occupational Health at 410 955-1617

GENERAL INFORMATION

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

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

Date of Birth _____ / _____ / _____ Sex: ☐ Male ☐ Female

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)*

☐ Faculty ☐ Academic Staff ☐ Post-Doc Fellow
☐ Undergraduate Student
☐ Graduate Student ☐ Civil Service Staff ☐ Volunteer
☐ Employee ☐ Other _____

Occupation: *(Check one)*

☐ Graduate Student ☐ Animal Care Worker/Handler ☐ Lab Technician
☐ Research/Teaching Personnel ☐ Veterinarian ☐ Veterinarian Technician
☐ 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. When applying for the Animal Exposure Surveillance Program please **list all animals** you will be working with

   _____
4. 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

5. 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: _____
6. 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: _____

7. Are any agents of the following hazardous groups used in these animals?
   ☐ Infectious ☐ Teratogenic/Carcinogenic ☐ Radioactive ☐ Other: _____

8. Please list if checked: _____

9. Check the boxes below if you have been in contact with the following animals. Please specify contact hours/day, total duration (months), and months.

ANIMAL	Previously	Currently	Never	Contact Hours/Day	Total Months	Months At JH
Rats	☐	☐	☐			
Mice	☐	☐	☐			
Rabbits	☐	☐	☐			
Guinea Pigs	☐	☐	☐			
Old World Monkeys (Baboon, Macaque, etc.)	☐	☐	☐			
New World Monkey (Squirrel, Marmoset, etc.)	☐	☐	☐			
Cattle	☐	☐	☐			
Dogs	☐	☐	☐			
Hamsters	☐	☐	☐			
Gerbils	☐	☐	☐			
Prairie Dogs	☐	☐	☐			
Sheep	☐	☐	☐			
Goats	☐	☐	☐			
Swine	☐	☐	☐			
Other	☐	☐	☐			

If other animal, please specify: _____

HOME ENVIRONMENT INFORMATION

10. 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	☐	☐	☐	☐
Cats	☐	☐	☐	☐
Other (Type): _____	☐	☐	☐	☐

11. Please List Your Hobbies: _____

12. Do you smoke cigarettes? ☐ Yes ☐ No

13. Do you think you may have non-pet mice or other animals in your home? ☐ Yes ☐ No

FOR WOMEN ONLY

14. Are you pregnant? ☐ Yes ☐ No

    Are you planning to be pregnant in the next year? ☐ 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:

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

16. 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? _____

17. Have you ever been treated for the following diseases? ☐ Yes ☐ No

If yes, please check the illnesses:

☐ Emphysema	☐ Tuberculosis	☐ Liver Disease
☐ Shortness of Breath	☐ Arthritis	☐ High Blood Pressure
☐ Pneumonia	☐ Epilepsy	☐ Other
☐ Chronic Bronchitis	☐ Recurrent Bronchitis	

18. List prescribed and over the counter medications:

Name of Medication	Reason for taking	Last time taken

19. Have you ever had an occupational illness or injury? ☐Yes ☐No If yes, when?
_____

What happened? _____

_____

20. Did this injury or illness cause:
☐ permanent change of position ☐ temporary assignment ☐ termination of a job

21. Did you ever receive workers' compensation? ☐Yes ☐No

ALLERGY HISTORY

22. Do you think that you are allergic to any of these animals? (having symptoms of: Shortness of Breath, Hives, Swelling of Throat, Face, Rash, or Anaphylaxis) ☐Yes ☐No
If yes, please check all that apply below and provide required medical documentation of such allergic reactions:
☐ Rats ☐ Mice ☐ Rabbits ☐ Guinea Pigs ☐ Monkeys ☐ Cattle
☐ Dogs ☐ Cats ☐ Hamsters ☐ Gerbils ☐ Prairie Dogs ☐ Dogs
☐ Sheep ☐Goats ☐ Swine ☐ Other (specify) _____

23. Were you ever told by a doctor that you had allergies? ☐ Yes ☐ No

If yes, please list allergies (i.e. food, medications, seasonal, animal, eggs, environmental, & latex)

_____

_____

24. 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: _____

25. Have you ever received allergy (desensitization/immunotherapy) shots? ☐Yes ☐No

If yes, what year did you receive the shots? _____

26. 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? _____

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.

If working with New or Old World Primates – Please provide documentation of vaccine and blood work history.

VACCINE		Date Received	VACCINE		Date Received	VACCINE		Date Received
Measles	☐		Mumps	☐		Rubella	☐	
Hepatitis A	☐		Hepatitis B	☐		CMV	☐	
Toxoplasmosis	☐		'Q' Fever	☐		Vaccinia (smallpox)	☐	
Rabies	☐		BCG	☐		Varicella (chickenpox)	☐	
Date of last rabies booster:								

****If working with Bats please provide documentation of rabies immunizations, boosters, & last rabies titer.**

Date of last tetanus booster (TD or TDAP – Tetanus,Diptheria, Pertussis)	

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

VACCINE RECORD: ☐ Reported by Patient ☐ Medical Documentation Provided

TUBERCULOSIS SCREENING

28. Date of last PPD skin test/TSpot,/Quantiferon: _____ / _____ / _____ ☐ Positive ☐ Negative

Known history of Positive TB testing: ☐ Yes ☐ No Date when determined Positive: _____

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

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

☐Weight loss ☐Shortness of breath ☐ Chronic cough ☐ Bloody sputum ☐Fever

CHECKLIST - FOR OH CLINICAL STAFF USE ONLY

Employee working with Animals in ☐ Category 1 ☐ Category 2 ☐ Category 3 ☐ Category 4

☐ 2 Copies of Certificate given

List Allergies& Asthma (i.e. animals, eggs, environmental, food, latex, medications, seasonal) see Pg. 4 # 22, 23, 24, 25

_____

_____

☐ Tetanus, Diphtheria (TD)/Tetanus, Diphtheria, Pertussis (TDAP) within 10 years (See Pg. 4 #27)

☐ Documentation of prior rabies immunization if working with Bats or Rabid animals. (See Pg. 4 #27)

☐ Documentation of last PPD, TSpot, or Quantiferon within the last year. (See Pg. 5 #28)

☐ Category 3 – date and results of last titers (MMR, Var, HepB)

Lab work drawn ☐ Yes ☐ No

Does employee have any animal restrictions ☐ Yes ☐ No

If yes, Please list the animals allergic to _____

☐ Written copy of HSE 807 Policy given

☐ Animal Surveillance Program Information Sheet reviewed and given

☐ Educated patient on the functions & locations of OH, OIC, & HSE

☐ Offered patient Td/Tdap – patient declined

Comments: _____

_____

_____

_____

_____

Clinical Review By: _____ Date: _____

JOHNS HOPKINS
MEDICINE
Occupational Health
98 N. Broadway, Suite 421
Baltimore, MD 21231
410-955-6211 / FAX 410-955-1617

DEMOGRAPHIC INFORMATION (PLEASE PRINT CLEARLY)

SOCIAL SECURITY #:_____ **DATE OF BIRTH:**_____

NAME: _____
First Middle Maiden Last

ADDRESS: _____
Number Street Apt#

_____
City State Zip

PHONE: _____
Home Cell Work

CONTACT: _____
Email Fax Pager

SEX: M ☐ **or F** ☐ **NATIONALITY**_____ **RACE**_____ **ENGLISH SPEAKING:** ☐ **Y or** ☐ **N**

MARITAL STATUS: SINGLE: _____ **MARRIED:** _____ **DIVORCED:** _____ **WIDOWED:** _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE: _____

MOTHER'S NAME: _____
First Maiden

FATHER'S NAME: _____
First Last

HAVE YOU EVER BEEN TREATED AT THE JOHNS HOPKINS HOSPITAL? ☐ **Y or** ☐ **N**

HAVE YOU EVER BEEN EMPLOYED BY THE JOHNS HOPKINS HOSPITAL OR UNIVERSITY?

YES_____● _____ **NO**_____ **IF YES, WHICH ONE:** _____

MEDICAL HISTORY NUMBER: _____**(STAFF USE ONLY)**