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 Animal Care Facility.

Please fill out completely (Print or type)

_____
Name (Last, First, Middle Initial) Date of Birth

_____
Position Faculty Advisor

_____
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?

Animal	1-2 years	2-3 years	3-4 years	Over 4 years
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. Will you or do you perform functions that will involve aerosolization of toxic chemicals?
   Yes ____: Protocol #_____ No____ Don't know _____

2. Will you or are you required to lift animals, supplies or equipment exceeding 50 pounds?
   Yes ____ No____ Don't know _____

3. Do you have a previous illness/injury that will require special accommodations?
   Yes ____ No____ Don't know _____

4. Are you immunocompromised?
   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				

If you are currently working with animals do you use or wear any of the following items:

PPE	Yes	No	NA
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
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? 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)

Will you be working with primates? Yes_____ No_____

If you will be working with primates please answer the following questions:

Most recent tuberculin testing: PPD Date/year _____ mm induration _____

Have you had a chest X-ray related to a positive PPD tuberculin test? Yes_____ No_____
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: _____

Reviewed by: _____ Date: _____
(Print)

Title: _____ Signature: _____

Recommendations and Comments: