

Occupational Health Program: Medical Questionnaire Form

Columbia University Health History for Students and Personnel with Animal Contact

 Check one box: **ICM** **Animal Research Program** Baseline Periodic
Name: _____

UNI: _____

Date of Birth: ____/____/____

Hire Date: _____

Telephone #: _____

Campus Mailing Address: _____

Department/Section: _____

 Female Male

Supervisor Name: _____

Office Phone: _____ Fax #: _____

Prior to beginning laboratory research with any of the vertebrate species listed below, personnel including students are required to have a brief medical history and physical. Please schedule an appointment as follows:

1. Students not working with macaques are to contact Student Health on their respective campuses e.g., at CUIMC contact Health on Haven 212-305-3400, at Morningside contact Columbia Health 212-854-7426, and at Barnard College contact Primary Care Health Service 212-854-2091.
2. Students working with macaques must receive clearance at Workforce Health & Safety (WHS) instead of Student Health
3. Personnel (faculty and staff) are to contact their Supervisor to schedule an appointment with Workforce Health & Safety (WHS).

 Upon completion, WH&S or Student Health will provide a "clearance" e-mail to iacuc@columbia.edu.

Laboratory Animal Use: (Select which statement is applicable to your status)

1. I will not handle animals but will be working in areas where animals are housed (*administrative and facilities personnels please skip page to #2*).
2. I will be working with animals or animal body parts.
3. I am involved in veterinary care or animal husbandry.
4. I am working with human specimens (cells, body fluids, etc.) in conjunction with animal studies.

*The following does **not** apply to Administrative or Facilities Personnel*

Must be completed by Principal Investigator, Supervisor or Department Administrator:

1. Species contact within Columbia University/Barnard (Fill-in all that apply):
 - Nonhuman primate (Baboon, Macaque, Marmoset etc.), please specify _____
 - Calves, Sheep (state female or male), or Goat, please specify _____
 - Rabbits/Rodents (mice, rats, hamster, gerbil, guinea pig), please specify _____
 - Animal blood & bodily fluids & unfixed tissues
 - Dogs/Ferrets
 - Cats
 - Pigs
 - Bats
 - Reptiles
 - Fish
 - Amphibia (frogs)
 - Birds
 - Other, please list: _____
2. Frequency of animal contact (select which statement is applicable)

Daily 1-3 times/week 1-3 times/month infrequent (1-6 times/year)
3. For use with live animals ONLY, any work with potential exposure to:

Bloodborne Pathogens in human-derived materials	Yes <input type="checkbox"/> No <input type="checkbox"/>	please list: _____
Infectious Agents where vaccination is available	Yes <input type="checkbox"/> No <input type="checkbox"/>	please list: _____
Biological toxins where vaccination is available	Yes <input type="checkbox"/> No <input type="checkbox"/>	please list: _____

* Principal Investigator, Supervisor or Department Administrator signature required*

Date

* Principal Investigator, Supervisor or Department Administrator Print Name required*

Phone #

Must be completed by personnel including students:

1. Are you taking any prescription medication? Yes No
If yes, please list: _____
2. Are you immunosuppressed or taking any immunosuppressant drugs? Yes No
Have you had a splenectomy? Yes No
3. Do you have any allergies to animals, birds, food, latex/rubber products, or chemicals? Yes No
If yes, please explain: _____
(Employees with suspected work related allergies will be evaluated and be referred to the appropriate health care provider by WH&S)
4. Do you have asthma? Yes No
5. If female, are you pregnant? Yes No
6. If you are in contact with sheep:
Do you have valvular heart disease, congenital heart defects or prosthetic heart valves? Yes No
7. Do you have pre-existing hepatitis? Yes No
8. Have you ever had arthritis? Yes No
9. Have you ever been diagnosed as having a hernia? Yes No
10. Have you ever had back trouble or pain that required treatment or loss of time at work? Yes No
11. Do you have any current health problems that may interfere with your duties at work? Yes No
If yes, please describe: _____
12. Do you have contact with animals outside of work (i.e. pets, wild animals, farm animals)? Yes No
If yes, please describe: _____
13. Have you ever contracted an illness or had a serious injury from an animal or in animal-related work?
 Yes No
If yes, please explain in detail: _____

14. What is the date of your most recent tetanus vaccine (TT, TD, or TDAP) booster? _____
15. Have you completed a rabies vaccination (3 doses) series? Yes No If YES, when? _____
Have you ever had a rabies booster? Yes No If YES, when? _____
16. If you are in contact with nonhuman primates:
Have you ever had tuberculosis? Yes No
Have you been vaccinated (BCG) for tuberculosis? Yes No
Date of Last Chest X-ray: _____
Dates of treatment for Latent TB: _____
17. Please note any other health history you consider significant:

18. Does this study involve travel outside of the United States? Yes No
If YES, contact Student Health for Travel Assessment prior to travel.
19. ***If working with Infectious and/or Hazardous Agents/Toxins:***
Are you required to use a respirator? Yes No
If YES, a separate medical questionnaire **MUST** be completed at WH&S or Columbia Health prior to fit testing.

FOR STUDENT HEALTH OFFICE USE ONLY

DATE

DATE

Quantiferon tuberculosis test _____

Rabies vaccine #1: _____

Chest X-ray result: _____

Rabies vaccine #2: _____

MMR Titer: _____

Rabies vaccine #3: _____

MMR #1 Vaccine: _____

Rabies vaccine booster: _____

MMR #2 Vaccine: _____

Varicella Vaccine #1: _____

Polio Vaccine #1: _____

Varicella Vaccine #2: _____

TT/TD/TDAP Vaccine: _____

Blood borne Pathogen Surveillance:

Hep B Surface Ab: _____

Toxoplasma Ab, IgG (*females working with cats only*): _____

HBV Vaccine #1: _____

Q Fever Ab, IgG: _____

HBV Vaccine #2: _____

Waiver: _____

HBV Vaccine #3: _____

HBV Vaccine declination form signed: _____

HCV Ab (Hep C virus Antibody): _____

Notes: _____

* Faculty/Staff/Student Signature

Date

* Healthcare Provider/Reviewer Name, Title & Signature

Date