OCCUPATIONAL HEALTH SERVICES

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

University Health Services
910 Madison Ave, Suite 922
Memphis, Tennessee 38163
901-448-5630 Office
901-448-7255 Fax

Initial Health Questionnaire

PART A :(**TO BE COMPLETED BY EMPLOYEE OR STUDENT WITH THE ASSISTANCE OF THE HIRING MANAGER OR SUPERVISOR**.)

Section 1.0: Occupational Exposure

Section 1.1: Job Information

Employee _____Sex M☐ F☐ D.O.B _____Date_____
(**Last, First, Middle Initial**)

Address _____

Employer _____ Job title _____

Work Phone_____ Cell Phone _____Email address_____

Employee ID Number _____

Dept. / Building _____Room **#** _____

PI/Supervisor Name _____ Phone **#** _____

PI/Supervisor email address _____

Position description: (check all that apply)

☐Animal Caretaker/Technician ☐Laboratorian /Research Associate ☐Visitor

☐Principle Investigator ☐Researcher ☐Volunteer

☐IACUC Member ☐Environmental Health and Safety

☐UT Police/Security ☐Veterinary

☐Custodial Services ☐Facilities (HVAC, painter etc.)

☐Post doc/fellow ☐Office/Administrator

☐Student (i.e. UT, U of M, BCHS – etc.) ☐Summer or Short Term Student **only**

Section 1.2: Workplace Environmental (check all that apply)

Indicate the Workplace type(s) below that the position requires work or access to.

☐RBL ☐Research Laboratory ☐Animal Care Facility

☐Teaching Lab ☐Access to all workplaces (i.e. Custodial Services, EH&S, Police)

☐Office/Admin. ☐Clinical labs ☐Hospital/Nursing School

☐Other: _____

☐Yes ☐ No Does this position require access to restricted areas such as laboratories that use biological hazards or animal research laboratories in any of the workplaces indentified above? If 'YES', identify the highest biosafety level where access is required.

☐BSL 1 ☐BSL 2 ☐BSL 3 ☐All Levels

If any workplace boxes were checked in Section 1.2, continue to Section 1.3. If not, proceed directly to Part B, Section 3.0: Medical Health History.

Section 1.3: Respirator Use

☐Yes ☐ No Does this position require that you wear a respirator (does not include surgical masks)?

If YES, click here and complete the OSHA Respirator Medical Evaluation Questionnaire.
If you have completed the required OSHA Respirator Medical Evaluation questionnaire in the past, complete the Respirator Medical Evaluation Short Form.

Section 1.4: Exposure Types (Check all that apply)

Please indicate whether this position requires work, contact or access to the following research materials or subjects by checking the applicable boxes below.

☐Animals ☐Biological Agents

☐Radiation or radioactive materials ☐Chemicals or toxins

☐Human Fluids, Tissue, Blood or cell lines ☐Non- Human fluids, tissue, or cell line

☐Teratogenic/Carcinogenic agents ☐Patients

☐Physical (Laser, noise, UV, Liquid N2) ☐other (indicate other type here)

Comment _____

If any boxes are checked in Section 1.4, continue to Section 2.0: Risk Assessment. If not proceed directly to Part B, Section 3.0: Medical History

Section 2.0 Risk Assessment

Section 2.1: Exposure to Animals

☐Yes ☐ No Does this position require contact with animals? If YES, identify the highest level and type (s) of animal species below.

☐ABSL 1 ☐ABSL 2 ☐ABSL 3 ☐All Levels

Rodents:

☐Gerbil ☐Guinea pig ☐Hamster

☐Mice ☐Rat ☐Voles

☐Mole rats ☐Other _____

Farm Animals:

☐Goat ☐Pig ☐Sheep (M/F)

Others:

☐Birds ☐Dogs ☐Fish

☐Reptile/Amphibian ☐Macaque ☐Rabbits

☐Cats ☐Ferrets ☐Raccoons

☐Opossums

☐Other Non-human primate _____

Section 2.2: Exposure to Infectious Agents

☐Yes ☐ No Does this position require work with known infectious agents? If YES, please identify the type(s) of infectious agents below

Risk Group 3:

☐Francisella tularensis ☐Mycobacterium tuberculosis ☐SARS

☐Herpes B virus ☐Rabies virus ☐Rift Valley Fever virus

☐Monkeypox virus ☐ Yersinia pestis ☐ Chlamydia psittaci

☐ Burkholderia pseudomallei

Risk Group 2:

☐Burkholderia Cepacia	☐Chlamydia Pneumoniae	☐Chlamydia Trachomatis
☐Hepatitis B	☐Japanese encephalitis	☐Measles
☐Salmonella	☐AAV virus	☐Adenovirus
☐Lenti virus	☐Retrovirus	☐ Plasmodium falciparum

☐Other_____

Risk Group 1:

List _____

Additional Information: _____

_____

_____

_____

_____

Signature from the employee and supervisor or PI is **required** to ensure Part A accurately describes the applicant's job and workplace environment. This form **must** have both signatures before being seen by a University Health provider.

_____	_____	_____
Employee/Applicant Name	Employee/Applicant Signature	Date
_____	_____	_____
Supervisor/Manager/PI	Supervisor/ Manager/ PI	Date

PART B: TO BE COMPLETED BY EMPLOYEE

This part is completed by the Employee or candidate holding the position identified in Section 1.1. Do not share any information from Part B of this questionnaire with anyone including managers, supervisor, PI's or human resources. After Part B is completed, the individual **MUST SIGN THE QUESTIONNAIRE**. Please submit the completed questionnaire to University Health Service's confidential fax (901) 448-7255 or email to Evelyn Lewis, Occupational Health Coordinator, elewis4@uthsc.edu.
(NOTE: All personal health and medical information provided in Part B is confidential and will be disclosed by UHS ONLY with the individual's written consent.)

Section 3.0: Medical Health History (Please answer all questions completely)

3.1: Personal Information

Employee _____Sex M☐ F ☐ Date of Birth_____Today's date_____
(**Last, First, Middle Initial**)

Address _____

Employer _____ Job title _____

Work Phone _____ Cell Phone_____ Email Address _____

Primary Care Provider (PCP) _____ Phone **#** _____

Emergency Contact _____ Relationship _____Phone **#** _____

Section 3.2: Review of Systems and Medical Conditions

Do you have or have you had any of the following? (Please check all that apply)

Cardiovascular

☐ Angina ☐Chest pain/tightness ☐ Heart attack
☐Heart murmur ☐irregular heart beat ☐High blood pressure
☐Congestive heart failure

Dermatological

☐ Skin rash ☐Other dermatological/skin disorders

Gastrointestinal

☐Difficulty in swallowing ☐Hepatitis A ☐ Hepatitis B
☐Hepatitis C ☐Liver Disease ☐Stomach/intestinal problems

Immunological

☐Severe allergic reaction ☐ Compromised immune function ☐Chronic stuffy nose

Musculoskeletal

☐Arthritis ☐Chronic back pain ☐Joint pain and stiffness

Neurological/Nerve

☐Loss of consciousness ☐Mental problems/depression ☐Seizures
☐Problems with hearing ☐Problems with speaking ☐Stroke
☐Transient Ischemic attack (TIA)

Endocrine

☐Diabetes ☐Other endocrine disorders

Ophthalmological

☐Itchy, irritated eyes ☐Problems with seeing

Pulmonary

☐Asbestosis ☐Asthma ☐Bronchitis
☐Chronic cough ☐Emphysema/COPD ☐Pneumonia
☐Shortness of breath ☐Tuberculosis ☐Other

Urological

☐Kidney disease ☐Other urological disorders

Section 3.3: Work Illnesses

☐Yes ☐ No Have you had an illness related to animal exposure as a result of your work?
If YES, DESCRIBE.

_____

_____

_____

Section 3.4: Medications (including Over-the-counter)

List the drugs, dosage, frequency, and purpose for taking prescribed medications.

Drug	Dosage	Frequency	Purpose

Section 3.5: Physical Limitation

Do you have a physical condition that would impair your ability to do any of the following?

☐Yes ☐ No Stand continuously for three (3) hours

☐Yes ☐ No Refrain from eating or drinking for three (3) consecutive hours or more?

☐Yes ☐ No Do you require an accommodation for any of the items marked 'YES' above?

If YES, describe the accommodation here.

_____
_____
_____
_____

☐Yes ☐ No Are you or your partner currently pregnant or planning to become pregnant? Read the following information: "Things you should know if you are pregnant."

Section 3.6: Immunizations and testing history

Check all immunization(s) received in the past:

☐Tetanus	☐Tdap (pertussis)	☐Hepatitis B
☐Measles	☐Mumps	☐Rubella
☐Varicella (Chicken Pox)	☐Influenza	☐Rabies
☐Yellow Fever	☐Q-Fever	☐BCG
☐Cholera	☐Hepatitis A	☐Other _____

Section 3.7: Tuberculosis Screening

☐Yes ☐ No Have you had a positive TB screening?

Last TB screening: (i.e. TB skin test, T spot, Quantiferon Gold, chest x-ray, TB symptom's checklist)

_____	_____	_____
Date	Type of Screening	Result

☐Yes ☐ No Have you ever taken Isoniazid (INH) therapy for TB? Year_____

Section 3.8: Allergies

This section requests that you identify allergies to laboratory animals or other allergies such as medications, latex, peanuts, etc.
☐Yes ☐ No Are you allergic to any laboratory animals? If YES, complete the Animal Allergy Screening Form and submit to Evelyn Lewis, Occupational Health Coordinator, elewis4@uthsc.edu or fax to the confidential fax (901) 448-7255.

☐Yes ☐ No Do you have any other known allergies? If YES, list the specific allergies and symptoms.
_____

Section 3.9: Smoking History

☐Yes ☐ No Current cigarette smoker _____
☐Yes ☐ No Current cigar smoker _____
☐Yes ☐ No Current pipe smoker _____
☐Yes ☐ No Previous smoker
How long since your last use of tobacco products? _____

Section 3.10: Corrective Lens

☐Yes ☐ No Do you wear glasses?
☐Yes ☐ No Do you wear contact lenses?
_____ Year of your last eye exam

Additional comments

_____

_____

_____

_____

_____

_____

My signature below indicates that I have answered the questions above truthfully, completely, and to the best of my ability.

Email your questionnaire to Evelyn Lewis RN, COHN-S, Occupational Health Coordinator elewis4@uthsc.edu or fax to (901) 448-7255.

_____ _____
Employee/Applicant Signature Date

Request for Occupational Health Services:

Hepatitis B vaccine series

Hepatitis B antibody titer

Tdap

TB screening

Rabies vaccine series

Rabies antibody titer

Measles, Mumps, Rubella (MMR) vaccine

Measles antibody titer

Respirator Medical Clearance

Respirator fit test

Medical Questionnaire Review for respirator

Hearing Screening

Vision exam (lasers)

Physical Exam

General Health Panel (GHP)

Pulmonary Function Test (PFT)

Urine Drug Screen (UDS)