

INTERIM MEDICAL QUESTIONNAIRE

The purpose of this questionnaire is to help protect you against possible illness that may be caused by working around animals, animal bedding or animal waste. In order to be useful, it is necessary that we review information about what you do in your work, as well as information about your general health status.

- **Completion of the questionnaire is a REQUIREMENT for your job**
 - To receive federal funds for research, the NIH requires an institution to provide an occupational health program to its employees who work with or around animals. In addition, MSU has elected to become accredited by AALAC which also requires such a program. The program requires MSU to assess the risk to each employee with animal contact.

- **The information you submit is CONFIDENTIAL, and will only be reviewed by health professionals within the University Physician's Office**
 - The health questions are related to 3 main health issues:
 - 1.) Respiratory allergies including asthma caused by working around animals.
 - 2.) Zoonotic diseases (infectious diseases from animals).
 - 3.) Immunosuppression, which may increase your risk of zoonotic diseases.

- **After reviewing the questionnaire, you will be notified of the results of the review**

We strongly recommend that you become familiar with the hazards associated with your job and use this information to minimize your risk of developing a work-related injury or illness.

MSU Occupational Health
Office of the
University Physician
East Lansing, Michigan
48824-1037
Phone: 517.353.9137
Fax: 517.355-0332

For information about the human health hazards of working with the specific animal species you are in contact with, please visit:

<http://safetyservices.ucdavis.edu/ps/occh/acuohp/pem/educationalMaterials>.

Information about health and safety issues related to working with animals or on a farm is available at the National Ag Safety Database's website: <http://nasdonline.org/>.

- **Individuals who work with animals may be bitten or scratched by an animal. It is highly recommended that you have a tetanus vaccine every ten years.**

Michigan State University
 University Physician's Office
 Occupational Health
 Phone: 517.353.9137
 Fax: 517.355.0332
 East Lansing, MI 48824-1037

Date: _____

**INTERIM MEDICAL QUESTIONNAIRE FOR
 INDIVIDUALS WITH ANIMAL CONTACT**

Name:			
Last	First	Middle	
Address:			
Street	City	State	Zip
Home Phone:	ZPID or APID:	Date of Birth:	
Department:	Job Title:		
Phone number we can reach you at work:	Supervisor:		
If a health care provider needs to reach you, what is the best time to call?			
What building(s) do you work in?			
Do or will you work with animals or work in rooms where animals are housed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", what kind of animals do you work with or come in contact with?			
Do or will you work with unfixed animal tissue?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", what animals and types of specimen?			
On the average over a year, how many hours a week do or will you work/have contact with these animals or specimens?			
How long do you plan to work at this job or a similar job with animals at MSU?			
Height (without shoes):		Weight (without shoes):	

1. Yes No Do you smoke cigarettes now?
2. Yes No Have you had a breathing test since you completed your last respirator/animal handler questionnaire?

IF YES, WHAT WERE THE RESULTS?

3. During the past year, for each of the following symptoms, indicate if you were bothered by the symptom at work. If you have the symptom, give the month and year you began to have the symptom.
- | | Yes | No | Month/Year |
|-----------------------------|--------------------------|--------------------------|------------|
| 3a. Itchy or irritated eyes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3b. Nasal stuffiness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3c. Runny nose | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3d. Sore or dry throats | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3e. Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3f. Cough | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3g. Chest tightness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3h. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3i. Skin rash | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**IF YES TO ANY SYMPTON IN QUESTION 3, PLEASE ANSWER 4a-4h.
IF NO, GO TO QUESTION 5.**

4. Yes No Have you ever had to seek medical treatment for the symptoms?

NAME THE TYPE OF MEDICAL CARE, MONTH/YEAR YOU FIRST SOUGHT MEDICAL CARE AND HOW MANY TIMES YOU USED THAT SOURCE OF MEDICAL CARE.

- | | Yes | No | Month/Year first seen by Physician | Number of Visits |
|-----|--------------------------|--------------------------|------------------------------------|------------------|
| 4a. | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |

- 4b. Yes No In the last year, have you missed work or had to leave work early because of any of these medical symptoms?

If YES, WHICH ONES? _____

- 4c. Do you find that many things cause symptoms or are your symptoms specific to one or certain things?

- Many things One thing A number of specific things Don't know

- 4d. What thing(s) or specific duties do you believe are causing the symptoms?

4e. Yes No Are you still exposed to the things causing symptoms?
IF NO, GIVE MONTH/YEAR LAST EXPOSED _____
AND INDICATE WHY NO LONGER EXPOSED:
 1. Been reassigned
 2. Type of animal replaced
 3. New engineering controls
 4. New respirator/dust mask
 5. Left job
 6. Other (if other, explain) _____

4f. Yes No Are the symptoms still present?

4g. If you had (have) wheezing, cough, chest tightness or shortness of breath answer the following:

- Yes No 1. Did the symptoms get worse during the day when you worked?
 Yes No 2. Are the symptoms worse on Monday or first day back to work (if you work weekends)?
 Yes No 3. Did the symptoms get better when you were away from work or on the weekends or vacations?
 Yes No 4. Did symptoms get worse when you went home after work?
 Yes No 5. Did the symptoms get worse throughout the workweek?

4h. Yes No Do you take medication for your breathing problem?
IF YES, LIST MEDICATION AND MONTH/YEAR STARTED.

	Name of Medication	Month/Year Started
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

4i. Yes No Do you take medication now?
IF YES, ARE YOU TAKING? Less Same More
 Your current medications are:

5. Yes No Did you have allergy testing in the past year?

6. Yes No Since completing your last animal contact questionnaire:
 Have you had any other chest illness?
IF YES, PLEASE SPECIFY _____

6a. Yes No Since completing your last animal contact questionnaire:
 Have you had diarrhea lasting 1 day or more?
IF YES, please estimate how many times in the past year _____

7. Yes No Don't know Have you had a tetanus vaccine in the last 10 years?

Read this before proceeding

Is it possible you will wear a respirator (a surgical mask is not considered a respirator) in the next year either as part of your regular work or if there is an emergency? Yes, No, Don't know

If the answer is no: You are done!

If the answer is yes or don't know: You are done unless you are due for your respirator certification. You can check your status at herd.msu.edu If the expiration of your respirator certification is in a few months or past due you will need to complete the rest of this questionnaire.

8. Will you wear a respirator (a mask that protects you against exposure to dusts or chemical fumes) in the coming year? Surgical masks are NOT considered respirators. If "Yes", check type (you can check more than one category):

- N, R, or P disposable respirator (filter-mask, non-cartridge type only).
- Other type (for example, half or full-face piece type, powered-air purifying, supplied-air self-contained breathing apparatus).

9. Yes No

Have you worn a respirator since completing your last animal contact questionnaire:

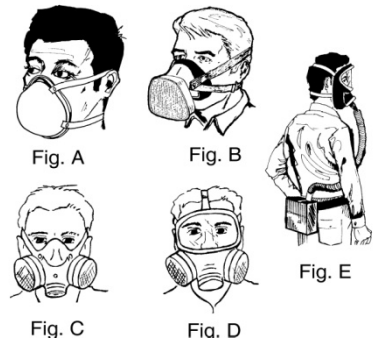
IF "YES", ANSWER QUESTIONS 8a-8i, IF "NO," SKIP TO QUESTION 10

- 9a. How often do you wear a respirator? (for example: 3 times per week, 10 times per month)
 _____ per week _____ per month _____ per year
- 9b. How long do you typically wear your respirator without taking it off? (for example: 15 min., .5 hours, 1 hour, 4 hours) _____
- 9c. What duties do you perform while using the respirator? (for example: painting, applying pesticides, cleaning, asbestos removal, etc...)

- 9d. Briefly describe your working environment while wearing your respirator. (For example: research lab, farm area, steam tunnel, penthouse, etc...)

9e. What type of respirator do you wear? (check **all** that apply)

- Disposable paper dust mask with 1 strap
- Disposable paper dust mask with 2 straps (Fig. A)
- Disposable organic vapor mask (Fig. B)
- Disposable organic vapor/acid gas mask (Fig. B)
- Reusable half-face mask (Fig. C.)
- Reusable full-face mask (Fig. D)
- Powered air purifying respirator (Fig. E)
- Full-face respirator with an air-line
- Self contained breathing apparatus (SCBA)
- Air-line w/ total body suit
- Other (please specify):



9f. Indicate, with a check, whether your usual workload level while you are wearing a respirator is resting, light, moderate or heavy. Also, indicate with a check, whether your maximum workload level while wearing a respirator is resting, light, moderate, or heavy.

Usual Max.

- Resting**
- Light** (examples include)—sitting at ease, light hand work, hand and arm work (small bench tools, inspecting, assembly, or sorting of light materials), arm and leg work. Standing: drill press (small parts), milling machine (small parts), machining with light power tools.
- Moderate** (examples include)—hand and arm work (nailing, filing), arm and leg work (off road operation of trucks or construction equipment), arm and trunk work (air hammer operation, tractor assembly, plastering, intermittent handling of moderately heavy materials, weeding, hoeing, pushing or pulling light weight cars or wheelbarrows).
- Heavy** (examples include)—heavy arm and trunk work, transferring heavy materials, shoveling, sledge hammer work, sawing, hand mowing, digging, axe work, climbing stairs or ramps, jogging, running, pushing or pulling heavily loaded carts or wheelbarrows, chipping castings, concrete block laying.

Have you ever had any of the following problems when you wore a respirator?

Yes No

9g. Eye irritation?

Yes No

9h. Skin allergies or rashes?

Yes No

9i. Anxiety?

Yes No

9j. Persistent general weakness or fatigue?

Yes No

9k. Any other problems that interfere with your use of a respirator?
If yes, what?

Yes No

9l. Describe any other difficulties that you had using the respirator?

Yes No

10.

Do you have a fear of tight or enclosed places (claustrophobia)?

11. Have you had any of the following conditions since completing your last animal contact questionnaire?

Yes No

11a. Epilepsy (or fits, seizures, convulsions)?

Yes No

11b. Diabetes?

IF "YES," Mark the treatment **DIET** **PILLS** **INSULIN**

Yes No

11c. Allergic reactions that interfere with your breathing?

Yes No

11d. Trouble smelling odors?

12. Have you had any of the following cardiovascular or heart problems since completing your last animal contact questionnaire?

Yes No

12a. Stroke?

Yes No

12b. Angina? (heart pain)

Yes No

12c. Heart failure?

Yes No

12d. Swelling in your legs or feet (not caused by walking)?

Yes No

12e. Heart arrhythmia (heart beating irregularly)?

13.

Has a doctor told you that you had a heart attack since completing your last animal contact questionnaire?

14.

Has a doctor told you that you had any other kind of heart trouble since completing your last animal contact questionnaire?

15.

IF "YES," PLEASE SPECIFY: _____
Do you have irregular or skipped heartbeats?

16. What was your most recent blood pressure? _____ / _____
You must provide a blood pressure reading done within the past year. If you have not had a blood pressure reading in the last year, have a blood pressure taken and record the result on the questionnaire before sending the questionnaire to the Occupational Health Clinic. You may also call the Occupational Health Clinic (353-9137) to schedule a time to have your blood pressure taken and you may return the questionnaire at that time.

17. Yes No Has a doctor told you that you had high blood pressure since completing your last animal contact questionnaire?

18. Yes No Have you had any treatment for high blood pressure (hypertension) since completing your last animal contact questionnaire?
IF "YES," PLEASE LIST THE MEDICATION(S) YOU TAKE FOR YOUR HIGH BLOOD PRESSURE:

19. Have you had any of the following cardiovascular or heart symptoms since completing your last animal contact questionnaire?

Yes No 19a. Pain or tightness in your chest that interferes with your job

Yes No 19b. Heartburn or indigestion that is not related to eating

Yes No 19c. Any other symptoms that you think may be related to heart or circulation problems?
IF "YES," PLEASE SPECIFY: _____

Within the past three months:

20. Yes No Have you had any pain or discomfort in your chest?

21. Yes No Have you ever had any pressure or heaviness in your chest?

**IF "YES" to either question 20 or 21, ANSWER THE FOLLOWING QUESTIONS.
 IF "NO" to questions 20 and 21, SKIP TO QUESTION 26.**

22. Yes No Do you get pain, discomfort, pressure, or heaviness when you walk uphill or hurry?
 I never hurry or walk uphill

23. Yes No Do you get pain, discomfort, pressure, or heaviness when you walk at an ordinary pace on level ground?

24. What do you do if you get pain, discomfort, pressure, or heaviness while you are walking?
 Stop or slow down
 Take nitroglycerine
 Keep going, without slowing down

25. If you stand still or sit down, what happens to this pain or discomfort?
 Not relieved Relieved

26. Yes No Did you see a doctor because of this pain or discomfort?
IF "YES," WHAT DID HE/SHE SAY IT WAS?

27. Yes No Have you had a back injury since completing your last animal contact questionnaire?
28. Do you currently have any of the following musculoskeletal problems?
 Yes No
 28a. Weakness in any of your arms, hands, legs, or feet
 Yes No
 28b. Back pain
 Yes No
 28c. Difficulty fully moving your arms or legs
 Yes No
 28d. Pain or stiffness when you lean forward or backward at the waist
 Yes No
 28e. Difficulties fully moving your head up or down
 Yes No
 28f. Difficulty fully moving your head side to side
 Yes No
 28g. Difficulty squatting to the ground
 Yes No
 28h. Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs.
 Yes No
 28i. Any other muscle or skeletal problem that might interfere with using a respirator?
 If "YES," please explain: _____
29. Yes No Do you have a ruptured ear drum?
30. Yes No Are you color blind?
31. Yes No Do you wear contact lenses?
32. Yes No Do you wear glasses?
33. Yes No Do you have any defect of vision (other than corrective lenses)?

IF "YES," STATE THE NATURE OF THE DEFECT:

34. Yes No Do you have any defect of hearing?

IF "YES," STATE THE NATURE OF THE DEFECT:

You are done! Please mail or fax this completed questionnaire to:

MSU Occupational Health
 Office of the University Physician
 463 E. Circle Dr. Room 123
 East Lansing, MI 48824

Fax: 517-355-0332