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 AAALAC 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.

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/article/zoonosis-information-species](http://safetyservices.ucdavis.edu/article/zoonosis-information-species)

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/](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.**
**INTERIM MEDICAL QUESTIONNAIRE FOR INDIVIDUALS WITH ANIMAL CONTACT**

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<th>Name:</th>
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<td>Last</td>
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<tr>
<th>Home Phone:</th>
<th>ZPID or APID:</th>
<th>Date of Birth:</th>
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<tr>
<th>Department:</th>
<th>Job Title:</th>
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<tr>
<th>Phone number we can reach you at work:</th>
<th>Supervisor:</th>
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If a health care provider needs to reach you, what is the best time to call? As specified by the individual.

What building(s) do you work in? As specified by the individual.

Do or will you work with animals or work in rooms where animals are housed? ☐ Yes ☐ No

If "Yes", what kind of animals do you work with or come in contact with? As specified by the individual.

Do or will you work with unfixed animal tissue? ☐ Yes ☐ No

If "Yes", what animals and types of specimen? As specified by the individual.

On the average over a year, how many hours a week do or will you work/have contact with these animals or specimens? As specified by the individual.

How long do you plan to work at this job or a similar job with animals at MSU? As specified by the individual.

Height (without shoes): Weight (without shoes): As specified by the individual.
1. □ □ Do you smoke cigarettes now?
Yes No

2. □ □ 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.

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<tr>
<td>3a.</td>
<td>Itchy or irritated eyes</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Month/Year</td>
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<td>3b.</td>
<td>Nasal stuffiness</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Month/Year</td>
<td></td>
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<td>3c.</td>
<td>Runny nose</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Month/Year</td>
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<td></td>
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<td>3d.</td>
<td>Sore or dry throats</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td>Month/Year</td>
<td></td>
<td></td>
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<tr>
<td>3e.</td>
<td>Wheezing</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Month/Year</td>
<td></td>
<td></td>
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<tr>
<td>3f.</td>
<td>Cough</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td>Month/Year</td>
<td></td>
<td></td>
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<tr>
<td>3g.</td>
<td>Chest tightness</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Month/Year</td>
<td></td>
<td></td>
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<tr>
<td>3h.</td>
<td>Shortness of breath</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Month/Year</td>
<td></td>
<td></td>
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<tr>
<td>3i.</td>
<td>Skin rash</td>
<td>Yes</td>
<td>No</td>
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IF YES TO ANY SYMPTOM IN QUESTION 3, PLEASE ANSWER 4a-4h.
IF NO, GO TO QUESTION 5.

4. □ □ 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.

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<td>4a.</td>
<td>Olin Health Center</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Month/Year first seen by Physician</td>
<td>Number of Visits</td>
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<td>4b.</td>
<td>Personal Physician</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Emergency Room</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Hospitalizations</td>
<td>Yes</td>
<td>No</td>
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4b. □ □ 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.  □  □  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.  □  □  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.  □  □  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.  □  □  Do you take medication now?
   **IF YES, ARE YOU TAKING?**
   Your current medications are:
   □  Less  □  Same  □  More

5.  □  □  Did you have allergy testing in the past year?

6a.  □  □  Since completing your last animal contact questionnaire:
   Have you had any other chest illness?  
   **IF YES, PLEASE SPECIFY**

6b.  □  □  Have you been diagnosed with cancer or immune deficiency?  
   **IF YES, PLEASE SPECIFY**
6c. □ □ 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 __________________**

6d. □ □ Yes No  Have you seen a doctor for diarrhea?
                  **IF YES, what was your diagnosis? ________________________________**

6e. □ □ Yes No  Have you seen a doctor for a skin rash?
                  **IF YES, what was your diagnosis? ________________________________**

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-8l, 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)?
- ( ) Yes
- ( ) No

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?
- ( ) Yes
- ( ) No

IF “YES,” Mark the treatment
- ( ) DIET
- ( ) PILLS
- ( ) INSULIN

11c. Allergic reactions that interfere with your breathing?
- ( ) Yes
- ( ) No

11d. Trouble smelling odors?
- ( ) Yes
- ( ) No

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)?
- ( ) Yes
- ( ) No

13. Has a doctor told you that you had a heart attack since completing your last animal contact questionnaire?
- ( ) Yes
- ( ) No

14. Has a doctor told you that you had any other kind of heart trouble since completing your last animal contact questionnaire?
- ( ) Yes
- ( ) No

IF “YES,” PLEASE SPECIFY:

15. 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:
   □ Yes □ No Have you had any pain or discomfort in your chest?

20. □ 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.

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

22. □ Yes □ No Do you get pain, discomfort, pressure, or heaviness when you walk uphill or hurry?
   □ Yes □ No 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