MICHIGAN STATE
UNIVERSITY

INITIAL 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.

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/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/browse/171/animals.html.

- **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.**

INITIAL MEDICAL QUESTIONNAIRE FOR INDIVIDUALS WITH ANIMAL CONTACT

Name:			
Last	First	Middle	
Address:			
Street	City	State	Zip
Home Phone: ( )	Gender: ☐ Male ☐ Female		
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) will you work in?			
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?			
Do or will you work with unfixed animal tissue? ☐ Yes ☐ No			
If yes, what animals and types of specimen?			
On the average, 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):		

Michigan State University
University Physician's Office
Occupational Health
463 East Circle Drive Room 123
East Lansing, MI 48824-1037
(517) 353-9137

1. Yes ☐ No ☐ Do you smoke cigarettes now?
2. Yes ☐ No ☐ Have you had a breathing test?
IF YES, WHAT WERE THE RESULTS?

_____

3. Yes ☐ No ☐ Have you ever had emphysema?
4. Yes ☐ No ☐ Have you ever had asthma?

IF "YES," ANSWER QUESTIONS 4a-4d. IF "NO," SKIP TO QUESTION 5.

Yes ☐ No ☐ 4a. Do you still have it?
Yes ☐ No ☐ 4b. Did a doctor confirm it?

4c. At what age did it start? _____

4d. If you no longer have it, at what age did it stop? _____

5. Yes ☐ No ☐ Have you ever had tuberculosis?
6. Yes ☐ No ☐ Have you ever had any other lung problems that you have been told about?
IF "YES," PLEASE SPECIFY:

_____

7. Yes ☐ No ☐ Have you ever had an attack of wheezing that made you feel short of breath?
IF "YES" TO QUESTION 7, ANSWER QUESTIONS 7a-7c. IF "NO," SKIP TO QUESTION 8.

7a. How old were you when your first attack of wheezing occurred? _____

Yes ☐ No ☐ 7b. Have you had two or more such episodes?
Yes ☐ No ☐ 7c. Have you required medicine or treatment for these attacks?

8. Yes ☐ No ☐ Do you usually bring up phlegm or mucus from your chest? (Count phlegm with first waking up or first cigarette or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.)
IF "YES" TO QUESTION 8, ANSWER QUESTIONS 8a AND 8b, IF "NO" SKIP TO QUESTION 9.

Yes ☐ No ☐ 8a. Do you bring up phlegm or mucus like on 4 or more days per week, for 3 consecutive months or more during the year?

8b. For how many years have you had trouble with phlegm or mucus?

9. When was your last general medical examination? _____
10. Yes ☐ No ☐ Do you have any chronic medical conditions?
IF "YES," WHAT DISEASES?

_____

11. Yes ☐ No ☐ Do you or did you have cancer or an immune deficiency?
IF "YES," TYPE AND YEAR OF DIAGNOSIS

Type	Year of Diagnosis

12. Yes ☐ No ☐ Do you take medicine that may suppress your immune system?
(Examples of such medications are prednisone or other steroids, chemotherapy or the anti-cancer agents, methotroxate, or cytoxan.)

13. Yes ☐ No ☐ Have you ever been told that you had allergies?
IF ''YES," TO QUESTION 13, ANSWER QUESTIONS 13a and 13b. IF "NO" SKIP TO QUESTION 14.

13a. Indicate what substances and at what age your allergies began?

Substance:	Age started:

Yes ☐ No ☐ 13b. Have you ever had allergy skin testing?
IF "YES," TO QUESTION 13b, ANSWER QUESTIONS 13c AND 13d, IF "NO" SKIP TO QUESTION 14.

13c. How many different positive skin tests to non-animal substances did you have? (Estimate if you don't know exact number)

13d. List animals you had positive skin tests to:

14. Have you had any of the following types of reactions when around animals?

Runny/stuffy nose	Yes ☐	No ☐	If yes, what animals?
Itching eyes	Yes ☐	No ☐	If yes, what animals?
Cough	Yes ☐	No ☐	If yes, what animals?
Wheezing	Yes ☐	No ☐	If yes, what animals?
Chest Tightness	Yes ☐	No ☐	If yes, what animals?
Shortness of Breath	Yes ☐	No ☐	If yes, what animals?
Skin Rash	Yes ☐	No ☐	If yes, what animals?

15. Yes ☐ No ☐ Have you ever taken medication for allergies (either needing a doctor's prescription or those you can buy yourself)?
IF "YES" TO QUESTION 15, ANSWER QUESTION 15a. IF "NO," SKIP TO QUESTION 16.

15a. List medicine(s) and year(s) taken?

Medication	Year(s) taken

16. Have you had problems with your bowels, including:

Yes ☐ No ☐ 16a. Blood in your stool?

Yes ☐ No ☐ 16b. Black stool (not dark brown)?

Yes ☐ No ☐ 16c. Diarrhea lasting 1 day or more?
IF "YES" TO QUESTION 16c, ANSWER QUESTION 16d. IF "NO" SKIP TO QUESTION 17.

16d. Please estimate how many times per year. _____

17. List all medication you take on a regular basis (include those you can buy without prescriptions). If you don't know the name, list what the pill is for (i.e., "heart pill or water pill")

18. Yes ☐ No ☐ Are you exposed to **HUMAN** blood or body fluids? (examples include: working with human controls/samples or work in the incinerator)
If "YES", Hepatitis B Surveillance Program sheet must be completed. The form is located online at: http://uphys.msu.edu/forms/HepBSurveillance.pdf

19. Yes ☐ No ☐ Do you have an increased work-related risk of exposure to rabies?
Answer "YES", if you work with non-lab mammals that come from outside MSU's campus or unfixed saliva specimens or specimens that may contain brain or nerve tissue from mammals. Answer "NO", if you work with only lab animals or animals that live in MSU controlled areas
If you have an increased rabies risk you must complete the Rabies Surveillance Record. The form is located online at:
http://uphys.msu.edu/forms/RabiesSurveillanceSheetwithvaccinerecord.pdf

Yes No Don't know

20. ☐ ☐ ☐ Have you had a tetanus vaccine in the last 10 years?

21. Check the type of respirator (a mask that protects you against exposure to dusts or chemical fumes) you will use, **surgical masks are not considered respirators**(you can check more than one category):

☐ 21a. N, R, or P disposable respirator (filter-mask, non cartridge type only).

☐ 21b. Other type (for example, half or full-face piece type, powered-air purifying, supplied-air self contained breathing apparatus).

21c. How often do you expect to wear a respirator? (for example: 3 times per week, 10 times per month)

21d. How long do you expect to typically wear your respirator without taking it off? (for example: 15 min., .5 hours, 1 hour, 4 hours)

21e. What duties will you perform while using the respirator? (for example: painting, applying pesticides, cleaning, asbestos removal, etc…)

21f. Briefly describe your working environment when you will be wearing your respirator. (For example: research lab, farm area, steam tunnel, penthouse, etc. . .)

Yes No

22. ☐ ☐ Have you ever worn a respirator:
IF "YES," ANSWER QUESTIONS 22a-22i. IF "NO," SKIP TO QUESTION 23.

22a. When was the last time, year? _____

22b. Check the type: ☐ N, R, or P filter type mask ☐ Cartridge ☐ helmet ☐ air tank

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

Yes No
☐ ☐ 22c. Eye irritation?

Yes No
☐ ☐ 22d. Skin allergies or rashes?

Yes No
☐ ☐ 22e. Anxiety?

Yes No
☐ ☐ 22f. Persistent general weakness or fatigue?

Yes No
☐ ☐ 22g. Any other problems that interfere with your use of a respirator?
If yes, what?

22h. Describe any other difficulties that you had using the respirator? _____

Yes No
☐ ☐ 22i. Did these difficulties make it so you were unable to use the respirator?

Yes No

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

24. Have you ever had any of the following conditions?

Yes No
☐ ☐ 24a. Epilepsy (or fits, seizures, convulsions)?

Yes No
☐ ☐ 24b. Diabetes?
IF "YES," Mark treatment: ☐ **DIET** ☐ **PILLS** ☐ **INSULIN**

Yes No
☐ ☐ 24c. Allergic reactions that interfere with your breathing?

Yes No
☐ ☐ 24d. Trouble smelling odors?

25. Have you ever had any of the following cardiovascular or heart problems?

	Yes	No	
25a.	☐	☐	Stroke?
25b.	☐	☐	Angina? (heart pain)
25c.	☐	☐	Heart failure?
25d.	☐	☐	Swelling in your legs or feet (not caused by walking)?
25e.	☐	☐	Heart arrhythmia (heart beating irregularly)?

26. ☐ Yes ☐ No Has a doctor ever told you that you had a heart attack?

27. 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.

28. ☐ Yes ☐ No Has a doctor ever told you that you had any other kind of heart trouble?
IF "YES," PLEASE SPECIFY:

29. ☐ Yes ☐ No Do you have irregular or skipped heartbeats?

30. ☐ Yes ☐ No Has a doctor ever told you that you had high blood pressure?

31. ☐ Yes ☐ No Have you had any treatment for high blood pressure (hypertension) in the past ten years?
IF "YES," PLEASE LIST WHAT MEDICATION(s) YOU TAKE FOR YOUR HIGH BLOOD PRESSURE:

32. Have you ever had any of the following cardiovascular or heart symptoms?

	Yes	No	
32a.	☐	☐	Pain or tightness in your chest that interferes with your job
32b.	☐	☐	Heartburn or indigestion that is not related to eating
32c.	☐	☐	Any other symptoms that you think may be related to heart or circulation problems. **IF "YES," PLEASE SPECIFY:**

Within the past three months:

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

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

IF "YES" TO EITHER QUESTIONS 32 OR 33, ANSWER THE FOLLOWING QUESTIONS.
IF "NO" TO QUESTIONS 32 AND 33, SKIP TO QUESTION 39.

35. ☐ Yes ☐ No Do you get pain, discomfort, pressure, or heaviness when you walk uphill or hurry?
☐ Never hurry or walk uphill

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

37. 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

38. If you stand still or sit down, what happens to this pain or discomfort?

☐ Not relieved ☐ Relieved

	Yes	No	
39.	☐	☐	Did you see a doctor because of this pain or discomfort? IF "YES," WHAT DID HE/SHE SAY IT WAS?
40.	☐	☐	Have you ever had a back injury?
41.	☐	☐	Do you currently have any of the following musculoskeletal problems?
	☐	☐	41a. Weakness in any of your arms, hands, legs, or feet.
	☐	☐	41b. Back pain.
	☐	☐	41c. Difficulty fully moving your arms and legs.
	☐	☐	41d. Pain or stiffness when you lean forward or backward at the waist.
	☐	☐	41e. Difficulties fully moving your head up or down.
	☐	☐	41f. Difficulty fully moving your head side to side.
	☐	☐	41g. Difficulty fully bending at your knees.
	☐	☐	41h. Difficulty squatting to the ground.
	☐	☐	41i. Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs.
	☐	☐	41j. Any other muscle or skeletal problem that might interfere with using a respirator. IF YES, please explain:
42.	☐	☐	Are you color blind?
43.	☐	☐	Do you have a ruptured ear drum?
44.	☐	☐	Do you wear contact lenses?
45.	☐	☐	Do you wear glasses?
46.	☐	☐	Do you have any defect of vision (other than corrective lenses)? **IF "YES," STATE THE NATURE OF THE DEFECT:**
47.	☐	☐	Do you have any defect of hearing?
48.	☐	☐	Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?

You are done! Please mail or fax this completed questionnaire to: MSU Occupational Health, 463 East Circle Drive, Room 123 Olin Health Center, East Lansing, MI 48824. Fax: (517) 355-0332