UNIVERSITY OF MIAMI
Employee Health Office
BASELINE MEDICAL SURVEILLANCE QUESTIONNAIRE

Please note: FAX this form **ONLY to the Employee Health Office** at 305-243-2393. **Do NOT fax this form to IACUC.**

Last name ___________________________First name ____________________ Employee ID#____________________

A. History of Laboratory Animal Contact

1. In the first column below, enter the letter that corresponds to how frequently you are currently exposed to laboratory animals.
2. In the second column, enter the amount of time that you work with animals on days that you work with them.
3. In the third column, enter the length of time that you have worked with each type of animal throughout your entire career.

Laboratory Animal Type	Frequency of current exposure a = never b = less than once a week c = 1-2 times a week d = 3-4 times a week e = daily f= monthly	Exposure Time (in hours/day)	Total time worked with animals in your career Months	Years
Dogs				
Guinea pigs				
Mice				
Primates				
Rabbits				
Rats				
Other (specify)				

B. Do you have any of the following symptoms that you feel are caused by, or made worse by the work environment where you come into contact with laboratory animals?

Symptom	Yes	No	Animal involved
Watery, burning or itchy eyes			
Runny nose			
Sneezing			
Wheezing			
Cough			
Shortness of breath			
Chest tightness			
Hives			
Rash			

What, if any, over-the-counter or prescription medications do you take for these symptoms:

____

C. Do you have a history of:

Asthma ☐**Yes** ☐ **No**

Hay fever ☐**Yes** ☐ **No**

Have you ever had a skin test performed to determine what your allergies are?

Yes ________ No ________

If "yes" what was the result? ______________________________________

Have you ever had a blood test performed to determine what your allergies are?

Yes ________ No ________

If "yes" what was the result? ______________________________________

Are you now, or have you ever been a cigarette smoker (one or more per week)?

Yes ________ No ________

If "yes" estimate how many cigarettes/day for how many years: ______________

What animals are you exposed to away from work?

____

Do you have any allergic symptoms to these pets? Yes ________ No ________

If "yes", what were the symptoms?

____

Vaccination History

Check the appropriate box. Please provide proof of vaccination.

Vaccine	Yes	No	If Yes, When
Hepatitis B			
Hepatitis A			
MMR			
Rabies			
Tetanus			
∗Tb skin test/screening			
Other			
Other			
Other			

∗ TB screening is done every 6 months for individuals working in high risk areas as well as with non-human primates.