Animal Workers Medical Surveillance
Confidential Medical History

University of Idaho

Employee Name: _____ Date of Birth: _____

SSN: _____ Sex: M / F _____

Work Phone:_____ Home/Cell Phone: _____

Address: _____City/State/ZIP:_____

The above information is required by the medical provider in order to process the form.

E-mail:_____

By providing an email address above, you are agreeing to allow the medical provider to email your Medical Recommendation Form instead of mailing a physical copy. The Medical Recommendation Form does not include any private health information.

Mark the species with which you have contact: Includes holding, feeding, cleaning, or handling of unfixed tissues	Average Hours of Contact per Week Work Related:	 Non-work Related:
☐ Cattle	_____	_____
☐ Pigs	_____	_____
☐ Sheep or Goats	_____	_____
☐ Horses	_____	_____
☐ Birds	_____	_____
☐ Fish	_____	_____
☐ Reptiles or Amphibians	_____	_____
☐ Rodents, if yes wild? Yes/No	_____	_____
☐ Other Wild Mammals (Elk, Caribous, Rabbits, etc.)	_____	_____
☐ Non-Human Primates (including tissues)	_____	_____
☐ Other (Please List) _____	_____	_____

Are any of the animals marked above:
Yes/No Purposely inoculated with human pathogens?
Yes/No Confirmed (versus suspected) to harbor or shed a human pathogen?
If yes to either of the above, please list agent(s): _____

Personal protective equipment I regularly use (check all that apply):

- ☐ Gloves
- ☐ Gown/Scrubs/Lab Coat
- ☐ Face Shield
- ☐ Respirator or Mask – Describe type _____

Yes/No Do you work with potentially biohazardous agents, including pathogens/infectious material, Biological Select Agents and Toxins, or human/primate blood or body fluid/blood products?

If yes, please list the agent/material and any other relevant information below:

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Employee Name: _____ Date of Birth: _____

Vaccination History:

Vaccination	Date of Receipt:
Tetanus	
Hepatitis B	
Rabies Series	

Directions: *Please place a check to the left of each item indicating whether you have ever had this condition. For each item checked "yes" indicate if this condition exists now, in the past and what treatment you receive(d) in the space is provided. If more space is needed, please use the back of the page.*

Yes	No	Allergy or Sensitivity to:	Now	Past	Treatment
		Pollens			
		Dust			
		Animal dander, feathers, or fur			
		Wood shavings or sawdust			
		Straw or hay			
		Medications or vaccines			
		Latex			
		Metal			
		Sunlight or cold			
		Cleaning soaps or detergents			
		Other factors not listed above			

Yes	No	Condition:	Now	Past	Treatment
		Allergic Reaction			
		Vision Problems			
		Hearing Problems			
		Skin Disease or Rash			
		Sinusitis			
		Hay Fever			
		Chronic Cough			
		Asthma			
		Tuberculosis			
		Diabetes			
		Neurological Disease			
		Heart Disease			
		Gastrointestinal Disease			
		Liver Disease			
		Kidney Disease			
		Reproductive Problems			

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		Arthritis			
		Back Pain			
		Bone or Joint Problems			
		Anemia or Blood Problems			
		Tumor or Cancer			
		Other Medical Conditions (please specify)			

Yes	No	Difficulty with:	Now	Past	Treatment
		Sensitivity to chemical, dust, sunlight or other factor			
		Performing certain motions			
		Other medical difficulties (if yes, please explain)			

Yes	No	Exposure to:	Now	Past	Comments
		Loud noises			
		If yes, do you wear hearing protection?			
		Smoke (cigarette, cigar, other)			
		If yes, average amount per day?			
		Other respiratory hazards?			
		Do you wear respiratory protection?			
		Do you have animals at home?			
		If yes, please list number and species.			

Please list all of your current medications and dosages:

Do you have specific concerns regarding your health relating to the handling of laboratory animals?

Females only: Are you currently pregnant: Yes / No
Are you planning a pregnancy in the next 12 months: Yes / No

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Employee Name: _____ Date of Birth: _____

Check one:

☐ I will **mail** my form. By signing/typing my name below I certify that I have reviewed the information supplied by me, and that it is accurate and complete to the best of my knowledge.

Mail to: Occupational Medicine Associates
323 E. 2nd Ave Suite 102
Spokane, WA 99202

☐ I will **email** my form. Email Client Services at: OccMedOMADL@multicare.org
By signing/typing my name below I certify that I understand I am submitting confidential information via email and that this method of delivery may not be entirely secure. This transmission is sent in trust for the sole purpose of delivery to the medical professionals for review and advice of risks. I certify that I have reviewed the information supplied by me, and that it is accurate and complete to the best of my knowledge.

_____ ____/____/____
Signature *Date*

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