Animal Workers Medical Surveillance
Medical History

University of Idaho
Environmental Health and Safety

Employee (print):_____**E-mail:**_____

Employee (Signature):_____**Work Phone:**_____

Date of Birth: _____ **Gender: M / F** **Home/Cell Phone:**_____

Address: _____**City/State/ZIP:**_____

Supervisor (print):_____

Supervisor (signature):_____

Department:_____

Budget # (or person to ask):_____

Description of research activities and animal species involved:

This form is submitted to and kept on file with the medical provider.
Page one is also submitted to EHS.

Animal Workers Medical Surveillance
Medical History

University of Idaho
Environmental Health and Safety

Employee's Name: _____

Directions: *Please have the employee place a check to the left of each item indicating whether s/he has ever had this condition. Have the employee explain each item checked "yes" in the blank space below and indicate if this condition exists now, in the past, and what treatment s/he received in the space is provided. If more space is needed, please use the back of the page. Providing the requested information is voluntary; the employee may decline to answer any or all of the questions. If s/he chooses not to answer a question, please have the employee initial the "decline" column.*

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

This form is submitted to and kept on file with the medical provider.
Page one is also submitted to EHS.

Employee's Name: _____

Do you have difficulty in any of the following areas?

DECLINE	YES	NO	CONDITION	NOW	PAST	TREATMENT
			Sensitivity to chemical, dust, sunlight or other factor			
			Performing certain motions			
			Other medical difficulties (if yes, please explain)			

Are you allergic to any of the following?

DECLINE	YES	NO	CONDITION	NOW	PAST	TREATMENT
			Pollens			
			Dust			
			Animal dander, feathers, or fur			
			Wood shavings or sawdust			
			Straw or hay			
			Medications			
			Vaccines			
			Metal or jewelry			
			Sunlight or cold			
			Cleaning soaps or detergents			
			Other factors not listed above			

Are you currently taking or have you taken any of the following within the past month?

DECLINE	YES	NO	MEDICATION	DOSAGE	FREQUENCY
			Antihistamines		
			Immunosuppressive drugs (such as cortisone, etc)		
			Allergy desensitization injections		
			Other medication taken routinely List:_____		

This form is submitted to and kept on file with the medical provider.
Page one is also submitted to EHS.

Employee's Name: _____

Are you exposed to the following?

DECLINE	YES	NO	CONDITION	NOW	PAST	COMMENTS
			Have you ever been a smoker?			
			If yes, average amount per day?			
			Do you work around loud noises?			
			Do you wear hearing protection?			
			Do you work around respiratory hazards?			
			Do you wear respiratory protection?			
			Do you have animals at home?			
			If yes, please list number and species.			

I certify that I have reviewed the foregoing information voluntarily supplied by me, and that it is accurate and complete to the best of my knowledge.

_____ _____/_____/_____

Employee's Signature *Date*

_____ _____/_____/_____

Physician's Signature *Date*

This form is submitted to and kept on file with the medical provider.
Page one is also submitted to EHS.