

B

You must complete Forms A, B and C

When complete, mail or fax this Form, along with Forms A and C, to -
SCOMC, 610 Frederick Street, Santa Cruz, CA 95062, secure fax (510) 653-5210.



Animal Contact Medical History Questionnaire

Purpose: Participants working with or in close proximity to research animals are required to complete this questionnaire. Your answers are confidential and need not be revealed to anyone except a healthcare provider. Based on your answers, the Santa Cruz Occupational Medical Center may contact you for further evaluation.

Instructions: Please complete this form. To protect your privacy, please put this form in a sealed envelope with Forms A and C. Mail all forms directly to SCOMC or send the forms to SCOMC via secure fax. **Receipt of all forms is required for medical clearance to work with research animals.**

Participant Name:

Job Title:

E-mail Address:

Work Phone:

Home Address:

Personal Phone:

Date of Birth:

Date of last Tetanus vaccine booster:

Yes No

Have you received the Hepatitis B vaccination series?

If Yes 1) Please list date:

2) Have you had your titer checked?

If titer has been checked, list date and result:

Please provide information on any allergies:

- Do you have known or suspected allergies to animals?
If Yes, please list:
- Do you have other known or suspected allergies?
If Yes, please list:
- Do you have asthma?
If Yes, list cause(s)?
- Do you have shortness of breath or wheezing?
If Yes, list cause(s)?
- Do you develop hives?
If Yes, list cause(s)?

List symptoms that occur when you are suffering from your allergies:

List treatment that you receive to relieve your allergies:

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Do you have any of the following medical conditions?

Yes No

- Diabetes
- Serious renal or liver disease
- Valvular heart disease
- Immune system deficiencies or other limitations to your ability to fight off disease
- Current therapy with high-dose steroids, radiation therapy, or cancer therapy
- History of problems with your spleen or absence of your spleen
- Pregnant or planning to become pregnant
- Are you currently using respiratory protection?
If Yes, 1) Please list type:
2) Have you been fit tested?

Do you have any health or workplace concerns not covered by this questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the occupational health clinicians at the Santa Cruz Occupational Medical Center?

Please list any current medications:

Authorization to Disclose Protected Health Information: I hereby authorize the disclosure of the specific information described above to Santa Cruz Occupational Medical Center. I acknowledge that I may be restricted from working with animals until cleared by SCOMC.

SIGNATURE

DATE

You will typically be asked to re-submit this form every 3 years, or sooner if advised by the SCOMC physician. If you experience a change in health status, e.g., pregnancy, illness requiring immune-suppressing drugs, health event requiring hospitalization, etc., it is your responsibility to contact your Supervisor and/or the SCOMC for additional medical evaluation for your work with animals. If you have questions on this form or the medical surveillance process, contact the Biological Safety Officer, (831) 459-2553 or biosafety@ucsc.edu.

Reviewed by:

REVIEWING CLINICIAN SIGNATURE

PID#

DATE