

# MICHIGAN STATE UNIVERSITY

## INITIAL MEDICAL QUESTIONNAIRE

This questionnaire is a requirement 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 to have information about what you do in your work, as well as information about your general health status.

This information will be kept confidential and only reviewed by health professionals within the University Physician's office. After reviewing the questionnaire, the health professional will send you a letter informing you whether any additional testing is recommended. Our aim in this assessment is to be compliant with accrediting and regulatory requirements, but more importantly to help you best protect your health at work.

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, or allergies or respiratory disease, which may increase some occupational risks.

More information about the human health hazards of working with the animal species you work with can be found at [https://occupationalhealth.ucdavis.edu/doc\\_links.php](https://occupationalhealth.ucdavis.edu/doc_links.php). Information about health and safety issues working with animals or on a farm is available at the National Ag Safety Database web site: [www.cdc.gov/NASD](http://www.cdc.gov/NASD).

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.



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**INITIAL MEDICAL QUESTIONNAIRE FOR  
 INDIVIDUALS WITH ANIMAL CONTACT**

Name:	
_____	_____
Last	First
_____	
Middle	
Address:	
_____	_____
Street	City
_____	
State	Zip
Home Phone: ( ) _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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 you work with animals or work in rooms where animals are housed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes", what kind of animals do you work with or come in contact with?	
Do you work with unfixed animal tissue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what animals and types of specimen?	
On the average, how many hours a week do 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): _____

1. Yes  No  Do you smoke cigarettes now?
2.   Have you had a breathing test?  
**IF YES, WHAT WERE THE RESULTS?**
- 
3.   Have you ever had emphysema?
4.   Have you ever had asthma?  
**IF "YES," ANSWER QUESTIONS 4a-4d. IF "NO," SKIP TO QUESTION 5.**
- 4a. Do you still have it?
- 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.   Have you ever had tuberculosis?
6.   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? \_\_\_\_\_
- 7b. Have you had two or more such episodes?
- 7c. Have you required medicine or treatment for these attacks?
8.   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.**
- 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.   Do you have any chronic medical conditions?  
**IF "YES," WHAT DISEASES?**
-



16.            Have you ever taken medication for allergies (either needing a doctor's prescription or those you can buy yourself)?

**IF "YES" TO QUESTION 16, ANSWER QUESTION 16a. IF "NO," SKIP TO QUESTION 17.**

16a. List medicine(s) and year(s) taken?

Medication

Year(s) taken

_____	_____
_____	_____
_____	_____

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

- 17a. Blood in your stool?  
        17b. Black stool (not dark brown)?  
        17c. Diarrhea lasting 1 day or more?

**IF "YES" TO QUESTION 17c, ANSWER QUESTION 17d. IF "NO" SKIP TO QUESTION 18.**

17d. Please estimate how many times per year.

18. 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")

19.            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>**

20.            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>**

21.            Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?

MEDICAL QUESTIONNAIRE FOR INDIVIDUALS WITH ANIMAL CONTACT THAT WEAR A  
RESPIRATOR

**IF YOU WEAR A RESPIRATOR, PLAN TO WEAR A RESPIRATOR, OR WILL HAVE A RESPIRATOR IN CASE OF AN EMERGENCY, PLEASE CONTINUE TO COMPLETE THIS QUESTIONNAIRE. IF NONE OF THE ABOVE APPLIES TO YOU, THEN YOU ARE FINISHED.**

22. Check the type of respirator (a mask that protects you against exposure to dusts or chemical fumes) you will use, (you can check more than one category):
- 22a. N, R, or P disposable respirator (filter-mask, non cartridge type only).
  - 22b. Other type (for example, half or full-face piece type, powered-air purifying, supplied-air self contained breathing apparatus).
  - 22c. How often do you expect to wear a respirator? (for example: 3 times per week, 10 times per month)
  
  - 22d. How long do you expect to typically wear your respirator without taking it off? (for example: 15 min., .5 hours, 1 hour, 4 hours)
  
  - 22e. What duties will you perform while using the respirator? (for example: painting, applying pesticides, cleaning, asbestos removal, etc...)
  
  - 22f. Briefly describe your working environment when you will be wearing your respirator. (For example: research lab, farm area, steam tunnel, penthouse, etc...)
23. 

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever worn a respirator:

**IF "YES," ANSWER QUESTIONS 22a-22i. IF "NO," SKIP TO QUESTION 24.**

23a. When was the last time, year? \_\_\_\_\_

23b. Check the type:    Paper (surgical) mask    Cartridge    helmet    air tank

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

  - 23c. Eye irritation?
  - 23d. Skin allergies or rashes?
  - 23e. Anxiety?
  - 23f. Persistent general weakness or fatigue?
  - 23g. Any other problems that interfere with your use of a respirator?  
If yes, what? \_\_\_\_\_
  - 23h. Describe any other difficulties that you had using the respirator?
  
  - 23i. Did these difficulties make it so you were unable to use the respirator?

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

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

  - 24a. Epilepsy (or fits, seizures, convulsions)?

- Yes      No  
    25b. Diabetes?  
**IF "YES," Circle treatment:**       **DIET**    **PILLS**    **INSULIN**  
    25c. Allergic reactions that interfere with your breathing?  
    25d. Trouble smelling odors?

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

- 26a. Stroke?  
    26b. Angina? (heart pain)  
    26c. Heart failure?  
    26d. Swelling in your legs or feet (not caused by walking)?  
    26e. Heart arrhythmia (heart beating irregularly)?

27.     Has a doctor ever told you that you had a heart attack?

28. 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.**

29.     Has a doctor ever told you that you had any other kind of heart trouble?  
**IF "YES," PLEASE SPECIFY:**

30.     Do you have irregular or skipped heartbeats?

31.     Has a doctor ever told you that you had high blood pressure?

32.     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:**

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

- 33a. Pain or tightness in your chest that interferes with your job  
    33b. Heartburn or indigestion that is not related to eating  
    33c. Any other symptoms that you think may be related to heart or circulation problems.  
**IF "YES," PLEASE SPECIFY:**

**Within the past three months:**

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

35.     Have you ever had any pressure or heaviness in your chest?

**IF "YES" TO EITHER QUESTIONS 34 OR 35, ANSWER THE FOLLOWING QUESTIONS.  
IF "NO" TO QUESTIONS 34 AND 35, SKIP TO QUESTION 41.**

36.     Do you get pain, discomfort, pressure, or heaviness when you walk uphill or hurry?  
 Never hurry or walk uphill

37.     Do you get pain, discomfort, pressure, or heaviness when you walk at an ordinary pace on level ground?

38. 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

39. If you stand still or sit down, what happens to this pain or discomfort?
- Not relieved
  - Relieved

40. Yes No  
  Did you see a doctor because of this pain or discomfort?  
IF "YES," WHAT DID HE/SHE SAY IT WAS?

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41. Yes No  
  Have you ever had a back injury?
42.   Do you currently have any of the following musculoskeletal problems?
- 42a. Weakness in any of your arms, hands, legs, or feet
  - 42b. Back pain
  - 42c. Difficulty fully moving your arms and legs
  - 42d. Pain or stiffness when you lean forward or backward at the waist
  - 42e. Difficulties fully moving your head up or down
  - 42f. Difficulty fully moving your head side to side
  - 42g. Difficulty fully bending at your knees
  - 42h. Difficulty squatting to the ground
  - 42i. Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs.
  - 42j. Any other muscle or skeletal problem that might interfere with using a respirator.  
IF YES, please explain:

43.   Are you color blind?

44.   Do you have a ruptured ear drum?

45.   Do you wear contact lenses?

46.   Do you wear glasses?

47.   Do you have any defect of vision (other than corrective lenses)?  
**IF "YES," STATE THE NATURE OF THE DEFECT:**

48.   Do you have any defect of hearing?  
**IF "YES," STATE THE NATURE OF THE DEFECT:**