Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210

(Place patient label here)

ANIMAL/BIOLOGICAL AGENTS CONTACT AND USE HEALTH QUESTIONNAIRE

Last Name: _____ First Name: _____

Date of Birth: _____ University ID#: _____

INSTRUCTIONS: Please complete the entire form (2 pages). The information you submit will be reviewed by the Student Life Student Health Services (SLSHS) Preventive Medicine provider.

PURPOSE: The questionnaire allows us to learn more information regarding your medical history, immunization status, and potential laboratory exposure risks. The provider will review all the submitted information and generate a list of recommended vaccines or testing that will allow you to participate in your research in the safest way possible. Depending on your current immunization status, you will either be cleared from the registry or it may be suggested you receive additional vaccines or testing at the cost of the department of Environmental Health and Safety.

CONFIDENTIALITY STATEMENT: SLSHS will maintain your rights to the confidentiality of your personal health information. **SLSHS will exchange health information with your academic program only for purposes of determining compliance with program requirements under the Family Educational Rights and Privacy Act (FERPA).**

Vaccines and Titers:

Vaccine	Yes / No	Indicate FULL dates given/received (MM/DD/YYYY)
Hepatitis A series (2)	☐ ☐	#1: _____ #2: _____
Hepatitis B series (3)	☐ ☐	#1: _____ #2: _____ #3: _____
MMR series (2)	☐ ☐	#1: _____ #2: _____
Rabies series (3)	☐ ☐	#1: _____ #2: _____ #3: _____
Tetanus booster (1)	☐ ☐	Most recent Tdap (Adacel, Boostrix) booster: _____
Blood titers (list titer name, date, and result):		

Tuberculosis Testing: TB skin test (PPD) or TB blood test (IGRA/QFT-G)

Date and result of most recent TB test	Date:	Result: positive / negative
If positive, date & result of most recent chest x-ray	Date:	Result: normal / abnormal

IF POSITIVE TB TEST, PLEASE INDICATE YES (Y) OR NO (N) FOR THE FOLLOWING SYMPTOMS:

Bloody sputum	Y	N	Fever	Y	N	Shortness of breath	Y	N
Chronic cough	Y	N	Night sweats	Y	N	Weight loss	Y	N

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Medical History

Condition	Yes / No	Date	Condition	Yes / No	Date
Arthritis	☐ ☐		Kidney disease	☐ ☐	
Lung disease	☐ ☐		Liver disease	☐ ☐	
Cancer	☐ ☐		Neurological disease	☐ ☐	
Diabetes	☐ ☐		Skin problems/eczema	☐ ☐	
Heart disease	☐ ☐		Heart murmur/valve replacement	☐ ☐	
Do you have a medical condition or take medications that impair your immune system? (such as HIV, steroids, chemotherapy/radiation)				☐ ☐	

Please list all medications, including non-prescription. Check here if none: ☐

_____

Please indicate any recent problems you have experienced while handling animals or chemicals:

Condition	Yes / No	Condition	Yes / No
Asthma	☐ ☐	Hay fever (dust)	☐ ☐
Chronic cough	☐ ☐	Hives or skin rash	☐ ☐
Chronic allergies (pollen, dust, dander)	☐ ☐	Itchy, irritated eyes (conjunctivitis)	☐ ☐
Allergy to latex gloves/powder in gloves	☐ ☐	Other:	☐ ☐

What types of animal/chemical exposures are these symptoms associated with? (dog, cat, chemical, etc.)

_____

Have these required any treatment with over-the-counter medications? (anti-histamines, decongestants, eye drops, etc.): Yes ☐ No ☐

Lab Exposures and Health Risks

Question	Yes / No	Comments
Will you be working with lung or lymph tissues?	☐ ☐	Specify: lung / lymph
Will you be working with human or other primate tissues?	☐ ☐	Specify: human / _____
Will you be working with Tuberculosis?	☐ ☐	
Are the animals you work with wild or caught?	☐ ☐	Specify: wild / caught
Are you pregnant or planning to become pregnant?	☐ ☐	

Signature (indicates the information above is correct to the best of your knowledge)

Patient Signature: _____ Date: _____

Submission / questions: Email preventivemedicine@osu.edu or call 614-247-2387.

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