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

Last	First	Middle Initial
(Place patient label here)		
ID #		

ANIMAL/BIOLOGICAL AGENTS CONTACT AND USE HEALTH QUESTIONNAIRE

Last Name: _____ First Name: _____

Date of Birth:_____ University ID#: _____ Department: _____

INSTRUCTIONS: Please complete entire form. The information you supply will be submitted to the Student Health Services Preventive Medicine staff for review.

PURPOSE: The purpose of this form is to obtain an individual health history for a student in contact with animals and other significant biological agents as part of their academic pursuits. It will be used within the Student Animal Handler program to evaluate appropriate medical surveillance needs.

VET MED: If you are an OSU Veterinary Medicine student and have already submitted your vaccine information to us or have been vaccinated at our facility, you may enter "SUBMITTED" in the sections below if applicable.

CONFIDENTIALITY STATEMENT: OSU Student Health Services will strictly maintain your rights to the confidentiality of your personal health information. **Student Health Services 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 Dates Given/Received
Hepatitis A series	☐ ☐	
Hepatitis B series	☐ ☐	
MMR	☐ ☐	
Rabies series	☐ ☐	
Tetanus	☐ ☐	
Other vaccines or titers (list with date):		

Tuberculosis Testing

Previous TB skin test (PPD)?	Yes ☐ No ☐ Unsure ☐	
If yes, give date and result of most recent test	Date:	Result: ☐ Positive ☐ Negative
If positive test, give date of most recent chest x-ray	Date:	Result: ☐ Normal ☐ Abnormal

If POSITIVE TB TEST in the past, please indicate Yes or No for any current symptoms:

Symptom	Yes/No	Symptom	Yes/No	Symptom	Yes/No
Bloody Sputum	☐ ☐	Fever	☐ ☐	Shortness of Breath	☐ ☐
Chronic Cough	☐ ☐	Night Sweats	☐ ☐	Weight Loss	☐ ☐

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Past Medical Conditions

If you have a prior history of the following conditions, please indicate the condition(s), and enter the date of onset (if known):

Condition	Yes/No	Date	Condition	Yes/No	Date
Arthritis	☐ ☐		Heart Murmur or Valve Disease	☐ ☐	
Lung Disease	☐ ☐		Immune suppression	☐ ☐	
Cancer	☐ ☐		Kidney Disease	☐ ☐	
Diabetes	☐ ☐		Liver Disease	☐ ☐	
Heart Disease	☐ ☐		Neurological Disease	☐ ☐	

Medications

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

_____

_____

Allergies

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)	☐ ☐	Itchy, Irritated eyes (Conjunctivitis)	☐ ☐

What types of animal or 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 ☐

Questions Regarding Exposure and Health Risks	Yes/No	Comments
Will you be working with lung, lymph, or primate tissues?	☐ ☐	
Are you working with non-colony felines or canines?	☐ ☐	
Are the animals you work with wild or feral?	☐ ☐	
Are you pregnant or planning to become pregnant in the next year?	☐ ☐ ☐ Not Applicable	

Signature

The above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

If you have any questions about this form, please contact Student Health Services Preventive Medicine by phone: 614-247-2387 e-mail: PreventiveMedicine@osu.edu or visit our website: www.shs.osu.edu

This information will now be evaluated. Student Health Services will contact you with additional information and recommendations.