University of Pittsburgh Animal Exposure Surveillance Program (AESP)

Initial Health Questionnaire 2026

Instructions for Enrollment

1. Complete this Animal Exposure Surveillance Program Health Questionnaire and Submit via **<u>one</u>** of the following below:

    1. **FAX:** 412-647-5051
    2. **Deliver:** *My*Health@Work for the University of Pittsburgh- Employee Health Services Clinic,
       3708 Fifth Avenue, **Medical Arts Building, Suite 505**, Pittsburgh, PA 15213
       between 7:00 a.m. and 3:30 p.m. Monday through Friday.
    3. **TEAMS Link –** https://www.ehs.pitt.edu/lab-safety/animal-research

2. **Do NOT send the completed form via campus mail.**
3. **Do NOT send the completed form to your supervisor.**
4. **Do NOT send the completed form to the Department of Environmental Health and Safety.**
5. **Do NOT send photos of completed form (scans only).**
6. **Do NOT put a campus address on form.**
7. **Please complete entire form.**

<u>Email of this form will not be accepted</u>

All information collected by this University of Pittsburgh program will be handled with the strictest confidence and in compliance with all applicable regulations. Your personal and medical information will only be available to those clinical care providers in Employee Health Services with a need to know.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employer and other entities covered by GINA Title II from requesting genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individuals’ family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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DEMOGRAPHICS

Name: _____ **Today's Date:** _____

Date of Birth: _____

Social Security Number (Required): _____

Home Address: _____ **City/State/Zip:** _____

Cell Phone: _____ **Work Email:** _____

Work Status (circle): Employee Student Visitor Other: _____

Department: _____

Job Position: _____

PI: _____

Supervisor: _____

OCCUPATIONAL REVIEW

What are your job responsibilities? _____

Do you have a history of working with animals? YES NO

If yes, which species did you work with? _____

When? (month/year) _____

Please X if applicable:

_____ I will not be working with animals or human/animal tissue, but this form is required for my lab's protocol.

TB REVIEW

Have you ever received the BCG vaccine? YES NO

Date of last TB screen (month/year): _____ **Type?** IGRA PPD/TST

Have you ever had a positive TB screening? YES NO

If yes, date of last chest x-ray? _____

If yes, were you treated with medication? YES NO

If yes, what medication(s) and when? _____

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INFECTIOUS DISEASE REVIEW

Please indicate if you have a history of immunization (I) or if you have worked with in the past (P) any of the following:

Infectious Agent	I	P	Infectious Agent	I	P
Avian Influenza	■		Influenza Viruses		
Bacillus anthracis			Japanese Encephalitis Virus		
Botulinum	■		Malaria	■	
Brucella	■		Mycobacterium tuberculosis		
Burkholderia	■		Orthopox Viruses (mpox)		
Chikungunya			Rabies		
Dengue	■		Rift Valley Fever Virus	■	
Eastern Equine Encephalitis Virus	■		SARS		
Francisella tularensis	■		Toxoplasma gondii	■	
Hepatitis A			Vaccinia		
Hepatitis B			West Nile Virus	■	
Hepatitis C	■		Yellow Fever Virus		
HIV	■		Yersinia pestis	■	
Human Retroviruses	■		Other:		

GENERAL REVIEW

What type of PPE have you used in the past? _____

_____

Do you have prior history of working with animals? YES NO

If yes, when? Month/Year: _____ to Month/Year: _____

Which species did you work with? _____

Do you have animals at home? YES NO

If yes, what kind of animal(s)? _____

Have you traveled outside the US within the last year? YES NO

If yes, to which country/countries? _____

If yes, have you had any health issues since returning? _____

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MEDICAL HISTORY

Please list any history of immunocompromised conditions (i.e. lupus, cancer, organ transplant, long-term medications like biologics or oral steroids, etc.):

_____

_____

Please list any chronic health conditions (i.e. diabetes, liver disease, heart disease, mood disorders, ADHD):

_____

_____

Please list any chronic respiratory diseases (i.e. asthma, COPD, etc.):

_____

_____

Please list any medications used to treat respiratory conditions:

_____

_____

Please list any other medications taken:

_____

_____

Date of last Tetanus booster (Tdap/TD): _____

Dates of MMR vaccination (for researchers working with measles, mumps, or nonhuman primates):

_____

ALLERGY HISTORY

Do you have prior history of allergy symptoms with animal exposures? YES NO

If yes, please list which animal(s) and associated symptom(s): _____

_____

Please list any medications used to control allergy symptoms: _____

_____

Are these medications effective in controlling allergy symptoms? YES NO

Do you use personal protective equipment (PPE) to control your allergy symptoms? YES NO

If yes, what type of PPE is used (i.e. gloves, mask, face shield, etc.)? _____

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If yes, is this PPE effective in controlling your symptoms? YES NO

Do you have or have you ever had a history of anaphylaxis? YES NO

If yes, what was the cause of the anaphylaxis? _____

Have you ever had allergy testing completed? YES NO

If yes, when? _____ **What were the results?** _____

Have you ever taken allergy injections? YES NO

If yes, when? _____ **Were they effective?** YES NO

Have you ever had a severe reaction to latex devices or products? YES NO

If yes, under what circumstances did the reaction occur and what were the associated symptoms?

_____

Have you ever been tested for a latex allergy? YES NO

If yes, when? _____ **What were the results?** _____

ATTESTATION

I certify that I fully understand all requests for information contained on this form and that the information supplied by me on this form is complete and correct to the best of my knowledge.

Signature: _____ **Date:** _____

FOR DUAL UNIVERSITY OF PITTSBURGH AND UPMC EMPLOYEES ONLY:

I hereby consent to my UPMC employee health information being accessed by University of Pittsburgh employee clinic staff for the purpose of occupational health or delivery clinical care and/or to confirm my vaccination/lab work status as an employee. (circle)

I AGREE or I DISAGREE

MYHEALTH@WORK STAFF ONLY

I have reviewed the information provided.

Signature: _____ **Date:** _____