UNIVERSITY OF OREGON

ANIMAL OCCUPATIONAL HEALTH QUESTIONNAIRE

This form must be completed upon entry into the Animal Occupational Health Program and every 3 years thereafter. ***Please complete in black ink and send to UHC (by fax @ 844-965-9250 or email to uhsoccu@uoregon.edu ONLY from a 'uoregon.edu' email account). DO NOT MAIL.***

Full Name _____ UO ID # _____ Gender _____

Date of Birth _____ Email _____ Phone _____

Local Address _____ City _____ State OR Zip _____

PI/Supervisor *Full Name* _____ Department _____

Departmental Billing Index Number for fees/charges _____ ***(REQUIRED)***

Billing Contact Name _____ Email _____

Billing Address _____

Employment Status: ☐ Faculty ☐ Staff ☐ GE ☐ Unpaid Student ☐ Animal Caretaker
(Check all that apply) ☐ Volunteer ☐ Intern ☐ Post-doc ☐ Other: _____

Do you have any allergies? If so, describe below.	☐ Yes	☐ No	☐ N/A
Do you have asthma?	☐ Yes	☐ No	☐ N/A
Do you feel you should *not* work with a certain species for health reasons (rodents/birds/aquatics)?	☐ Yes	☐ No	☐ N/A
Do you have any type of chronic infection? If so, describe below.	☐ Yes	☐ No	☐ N/A
Do you have a medical condition that impairs the immune system?	☐ Yes	☐ No	☐ N/A
Do you take any medications that might impair the immune system? If so, describe below.	☐ Yes	☐ No	☐ N/A
Are you pregnant or are you planning to become pregnant in the next year?	☐ Yes	☐ No	☐ N/A
Do you have any other significant medical conditions? If so, describe below.	☐ Yes	☐ No	☐ N/A
Have you been bitten or scratched by a lab animal?	☐ Yes	☐ No	☐ N/A
Since you last completed this form, have you contracted a disease from an animal?	☐ Yes	☐ No	☐ N/A
Since you last completed this form, have you had any illnesses, injuries, surgeries or hospitalizations?	☐ Yes	☐ No	☐ N/A

Approximate date of last tetanus booster: _____

Are you working with terrestrial wild-caught animals?	☐ Yes	☐ No	☐ N/A
If yes, have you had a rabies vaccination?	☐ Yes	☐ No	☐ N/A

For any 'yes' answers, or if you have health concerns not mentioned above, or if you wish to speak with the occupational health physician, please provide more information:

_____

_____

_____

If you have any workplace concerns (e.g., ergonomics, personal protective equipment, etc.) not covered by the questionnaire, fill out the Safety Concern Form and a representative will contact you.

SIGNATURE _____ **Date** _____

Note: The information on this form shall be kept confidential per state law. Its usefulness in protecting you and your environment from hazards depends on the accuracy of the information you offer. If you have intentionally elected to omit an answer(s) in this form, please check this box: ☐

Revised June 2021