CLAS OCCUPATIONAL HEALTH PROGRAM

BASIC HEALTH HISTORY FORM

DIRECTIONS: Complete the form online. Print the completed form on standard 8.5 x 11 paper, then sign and date. Make a copy for your records and email a copy to ***Dan Hurley- djhurley@northcarolina.edu*** This document will be maintained by Carolinas Healthcare System (CHS) as part of your permanent health record. Once you are cleared for enrollment in our Occupational Health Program, the IACUC Administrator and Research Program Administrator will be notified

For more information, contact: Dan Hurley

704-250-5056 OR djhurley@northcarolina.edu

PERSONAL INFORMATION:		**Date Submitted:**
LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
NCRC ID#	**EMAIL ADDRESS**	
LAB AFFILIATION	**DEPARTMENT**	**BUILDING/ROOM**
JOB TITLE	**DATE HIRED**	
HOME ADDRESS	**HOME PHONE**	
DATE OF BIRTH	**SEX: M/F** Select One	
EMERGENCY CONTACT	**RELATIONSHIP TO YOU**	
EMERGENCY CONTACT PHONE (HOME)	**EMERGENCY CONTACT PHONE (MOBILE)**	
PERSONAL PHYSICIAN	**PHYSICIAN PHONE**	**MAY WE CONTACT FOR MEDICAL INFORMATION?: Yes/No** Select One

A.NATURE OF EXPOSURE (check all statements applicable to your work situation)

In the scope of my work, I will:

- ☐ **Have direct exposure to non-human primates (EX. risk for bite/scratch/allergy)**
- ☐ **Have indirect exposure to non-human primates (EX. allergy only)**
- ☐ **Have direct exposure to rodents (EX. risk for bite/scratch/allergy)**
- ☐ **Have indirect exposure to rodents (EX. risk for allergy only)**

B.SPECIFIC RISK CATEGORIES (check all statements that apply to you)

1. Animal Product Hazard Exposure

- ☐ **Feces**
- ☐ **Urine**
- ☐ **Blood**
- ☐ **Fresh carcass or tissue**

OR

- ☐ **Not applicable [if you check this box, do not check any others on this question]**

2. Radiation Exposure (when working with animals or in the animal housing areas)

- ☐ **Research Nuclides--radioactive materials**
- ☐ **^{99m}Tc only**
- ☐ **Lasers** **List class:** _____
- ☐ **Other** **List:** _____

OR

- ☐ **Not applicable [if you check this box, do not check any others on this question]**

3. Biological Hazard Exposure (hazard to humans when working with animals or in the animal housing areas and/or to other animals in the animal housing areas)

Categories:

- ☐ **RDNA work that comes under the NIH Guidelines (i.e., requires approval minimally at the IBC level)**
- ☐ **BSL-1 organism**
- ☐ **BSL-2 organism**

Agents: Provide name(s)

- ☐ **Viruses:** _____
- ☐ **Bacteria:** _____
- ☐ **Yeasts:** _____
- ☐ **Molds:** _____
- ☐ **Protozoa:** _____
- ☐ **Other:** _____

OR

- ☐ **Not applicable [if you check this box, do not check any others on this question]**

4. Chemical/Laboratory Exposure (when working with animals or in animal housing areas)

☐ **Anesthetic gases** ☐ **Compressed gases in tanks** ☐ **Controlled drugs**

☐ **Adjuvants** ☐ **Toxins (Specify below)**

☐ **Carcinogens (e.g. alfatoxins,benzene, ethyl oxide)**

Please List: _____

☐ **Mutagens/Teratogens (e.g., cyclophosphamide, thalidomide, lead mercury)**

Please List: _____

☐ **Other toxins**

Please List: _____

☐ **Solvents (e.g., acetone, diethyl ether, methyl alcohol)**

Please List: _____

☐ **Flammables**

Please List: _____

C.ALLERGIES :(Check all appropriate boxes)

☐ **Animal** ☐ **Dust** ☐ **Medication** ☐ **Plant**

☐ **Pollen** ☐ **Venom** ☐ **Chemical** ☐ **Foods**

☐ **Specific Allergies, please list:** _____

D.IMMUNIZATIONS: (Check immunizations you have received and indicate most recent year of that immunization):

	Year:		Year:		Year:
☐ **Diphtheria**		☐ **Mumps**		☐ **Rubella**	
☐ **Hepatitis B**		☐ **Pertussis**		☐ **Tetanus**	
☐ **Influenza**		☐ **Polio**		☐ **Typhoid**	
☐ **Measles**		☐ **Rabies**		☐ **Smallpox**	

E. HEALTH HISTORY

State Your Main Health Concern(s):
Medications
Past Hospitalizations (Date, Why):
Cause/Duration of Sick Leave (past 5 years):
Past/Present Work Restrictions:
Other Diagnoses:

F.CURRENT HEALTH STATUS (Please check all that apply):

☐ Allergy Injection Therapy	☐ Anemia	☐ Appetite Loss	☐ Arthritis
☐ Asthma	☐ Back Injury	☐ Bloating/Gas	☐ Blood in Stool

☐ Blood in Urine	☐ Bruising	☐ Cough	☐ Diabetes
☐ Dizziness	☐ Drainage	☐ Dribbling/Hesitancy	☐ Earache
☐ Eye Pain, Blurring	☐ Fainting	☐ Fatigue/Weakness	☐ Fever
☐ Focal Numbness/Weakness	☐ Frequent Urination	☐ Tumor	☐ Hay Fever
☐ Headache	☐ Hearing Loss	☐ Heart Trouble	☐ Heartburn
☐ Hernia	☐ High Blood Pressure	☐ Voice Hoarseness	☐ Immune Deficiency
☐ Joint Swelling	☐ Loose Stools	☐ Loss of Balance	☐ Nausea/ Pain
☐ New/Changing Moles	☐ Nosebleeds	☐ Rash	☐ Ringing Ears
☐ Sickle Cell Anemia	☐ Sinus Congestion	☐ Sinusitis	☐ Sore Throats
☐ Speech Change	☐ Problem swallowing	☐ Swollen Glands	
☐ Upset Stomach	☐ Weight Loss	☐ Other: _____	

G. IF YOU WILL BE USING A RESPIRATOR, PLEASE COMPLETE THE SECTION BELOW (APPENDIX C TO SEC. 1910.134 **(A respirator is defined as any type of respiratory protection, including N-95 respirators. Nuisance dust masks are not considered respirators):**

APPENDIX C TO SEC. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Can you read? (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator.

1. Today's date: _____ 2. Your name:_____

3. Your age (to nearest year):_____ 4. Gender (check one): ☐ Male ☐ Female

5. Your height: _____ft. _____ in. 6. Your weight: _____ lbs.

7. Your job title:_____

8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the area code):_____ 9. The best time to phone you at this number:_____

10. Has your employer told you how to contact the healthcare professional who will review this questionnaire (Yes/No)? No

11. Check the type of respirator you will use (you can check more than one category):

a. N, R, or P disposable respirator (filter-mask, non-cartridge type only)

b. Other type (for example, half or full face piece type, powered-air purifying, supplied pair, self-contained breathing apparatus)

12. Have you worn a respirator (check one): ☐ Yes ☐ No

If "Yes", what type(s):_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "Yes" or "No" and clarify all Yes answers in the comments section).

		Yes	No
1.	Do you currently smoke tobacco or have smoked tobacco in the last month?	☐	☐
2.	Have you ever had any of the following conditions?	☐	☐
a.	Seizures (fits)	☐	☐
b.	Diabetes (sugar disease)	☐	☐
c.	Allergic reactions that interfere with your breathing	☐	☐
d.	Claustrophobia (fear of closed-in places)	☐	☐
e.	Trouble smelling odors	☐	☐
3.	Have you ever had any of the following pulmonary or lung problems?	☐	☐
a.	Asbestosis	☐	☐
b.	Asthma	☐	☐
c.	Chronic bronchitis	☐	☐
d.	Emphysema	☐	☐
e.	Pneumonia	☐	☐
f.	Tuberculosis	☐	☐
g.	Silicosis	☐	☐
h.	Pneumothorax (collapsed lung)	☐	☐
i.	Lung cancer	☐	☐
j.	Broken ribs	☐	☐
k.	Any chest injuries or surgeries	☐	☐
l.	Any other lung problem that you've been told about	☐	☐
4.	Do you currently have any of the following symptoms of pulmonary or lung illness?	☐	☐
a.	Shortness of breath	☐	☐
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c.	Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d.	Have to stop for breath when walking at your own pace on level ground	☐	☐
e.	Shortness of breath when washing or dressing yourself	☐	☐
f.	Shortness of breath that interferes with your job	☐	☐
g.	Coughing that produces phlegm (thick sputum)	☐	☐
h.	Coughing that wakes you early in the morning	☐	☐
i.	Coughing that occurs mostly when you are lying down	☐	☐
j.	Coughing up blood in the last month	☐	☐
k.	Wheezing	☐	☐
l.	Wheezing that interferes with your job	☐	☐

		Yes	No
m.	Chest pain when you breathe deeply	☐	☐
n.	Any other symptoms that you think may be related to lung problems	☐	☐
5.	Have you ever had any of the following cardiovascular or heart problems?	☐	☐
a.	Heart attack	☐	☐
b.	Stroke	☐	☐
c.	Angina	☐	☐
d.	Heart failure	☐	☐
e.	Swelling in your legs or feet (not caused by walking)	☐	☐
f.	Heart arrhythmia (heart beating irregularly)	☐	☐
g.	High blood pressure	☐	☐
h.	Any other heart problem that you've been told about	☐	☐
6.	Have you ever had any of the following cardiovascular or heart symptoms?	☐	☐
a.	Frequent pain or tightness in your chest	☐	☐
b.	Pain or tightness in your chest during physical activity	☐	☐
c.	Pain or tightness in your chest that interferes with your job	☐	☐
d.	In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e.	Heartburn or indigestion that is not related to eating	☐	☐
f.	Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7.	Do you currently take medication for any of the following problems?	☐	☐
a.	Breathing or lung problems	☐	☐
b.	Heart trouble	☐	☐
c.	Blood pressure	☐	☐
d.	Seizures (fits)	☐	☐
8.	If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following box and go to question 9): ☐ I have never used a respirator	☐	
a.	Eye irritation	☐	☐
b.	Skin allergies or rashes	☐	☐
c.	Anxiety	☐	☐
d.	In General weakness or fatigue	☐	☐
e.	Any other problem that interferes with your use of a respirator	☐	☐
9.	Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

Comments/Clarification (list number / letter of applicable question):

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

		Yes	No
10.	Have you ever lost vision in either eye (temporarily or permanently)?	☐	☐
11.	Do you currently have any of the following vision problems?	☐	☐
a.	Wear contact lenses	☐	☐
b.	Wear glasses	☐	☐
c.	Color blind	☐	☐
d.	Any other eye or vision problem	☐	☐
12.	Have you ever had an injury to your ears, including a broken ear drum	☐	☐
13.	Do you currently have any of the following hearing problems?	☐	☐
a.	Difficulty hearing	☐	☐
b.	Wear a hearing aid	☐	☐
c.	Any other hearing or ear problem	☐	☐
14.	Have you ever had a back injury?	☐	☐
15.	Do you currently have any of the following musculoskeletal problems?	☐	☐
a.	Weakness in any of your arms, hands, legs, or feet	☐	☐
b.	Back pain	☐	☐
c.	Difficulty fully moving your arms and legs	☐	☐
d.	Pain or stiffness when you lean forward or backward at the waist	☐	☐
e.	Difficulty fully moving your head up or down	☐	☐
f.	Difficulty fully moving head side to side	☐	☐
g.	Difficulty bending at your knees	☐	☐
h.	Difficulty squatting to the ground	☐	☐
i.	Climbing a flight of stairs or a ladder carrying more than 25 lbs	☐	☐
j.	Any other muscle or skeletal problem that interferes with using a respirator	☐	☐

Comments/Clarification (list number / letter of applicable question):

REVIEWED BY:_____ DATE:_____

H .OCCUPATIONALINFORMATION

List Titles of Jobs Held More Than 6 Months (if applicable):

Check Chemical/Physical Agents Used/Exposures:

☐ Animal Dander	☐ Commercial Diving	☐ Mercury	☐ Sun (>2hr/day)
☐ Arsenic	☐ Cotton Dust	☐ Methanol	☐ Welding Fumes
☐ Asbestos	☐ Formaldehyde	☐ Noise	☐ Wood Dust
☐ Benzene	☐ Lasers	☐ Pesticides	☐ X-rays
☐ Chlorinated Hydrocarbons	☐ Lead	☐ Radioisotopes	☐

☐ Solvents (name if known): _____

☐ Other Chemical Exposures: _____

Protective Equipment Used:

☐ Eyewear ☐ Safety Shoes ☐ Hearing Protection ☐ Respirator

Brand / Type of Respirator Used (if applicable):
Other:
Comments:

CAUTION: Some infectious diseases, including certain Zoonosis, are known to affect the fetus adversely. If you or someone in your household is pregnant or planning to become pregnant, please discuss your risk level with a healthcare professional prior to working with animals.

I hereby agree to immediately inform the *Occupational Health Coordinator (704-250-5056)* of any changes in the above history.

Signature: _____ Date:_____