Cornell University Animal Users Health and Safety Program (AUHSP)

AUHSP Medical Evaluation Form

INSTRUCTIONS: Please complete all applicable sections, sign the form, and return to:
Occupational Medicine, Cornell Health, 110 Ho Plaza, Ithaca, NY 14853-3101

Contact Cornell Health Occupational Medicine for assistance: 607-255-6960

Name (Last, First, M.I.)	**Cornell ID Number**
Preferred contact phone number (include area code)	**E-mail address**
Facility where research/animal exposure occurs	**PI or Supervisor**

A. TETANUS IMMUNIZATION

What is the year of your last tetanus immunization? ______________

(CDC and New York State Dept of Health recommend tetanus immunization every 10 years.)

B. ALLERGIES/ASTHMA/SKIN PROBLEMS

1. Are you allergic to any animal(s)? No Yes Don't know

   If yes, please list the animal(s) and their associated allergy symptoms:

   Have you had these animal allergy symptoms within the past 12 months? No Yes

   If yes, what is the current severity of your animal allergy symptoms? Mild Moderate Severe

   What animal allergy treatment are you currently using?

2. Are you allergic to any environmental allergens such as grass, trees, pollen, dust? No Yes Don't know

   If yes, please list environmental allergens and their associated allergy symptoms

   Have you had these environmental allergy symptoms within the past 12 months? No Yes

   If yes, what is the current severity of your environmental allergy symptoms? Mild Moderate Severe

   What environmental allergy treatment are you currently using?

3. Do you have asthma? No Yes Don't know

   If yes, please describe your asthma triggers (if known)

   Have you had asthma symptoms within the past 12 months? No Yes

   If yes, what is the current severity of your asthma symptoms? Mild Moderate Severe

   What asthma treatment are you currently using?

4. Do you have allergy or asthma symptoms specifically related to your work? No Yes Don't know

   If yes, please describe your allergy or asthma symptoms at work

   Have you had these symptoms within the past 12 months? No Yes

   If yes, what is the current severity of these symptoms? Mild Moderate Severe

   What treatment are you currently using for your work-related allergy or asthma symptoms?

5. Have you had any skin problems caused or exacerbated by your work activities? No Yes Don't know
   If yes, please describe the skin problem

   Have you had this skin problem within the past 12 months? No Yes
   If yes, what is the current severity of your skin problem? Mild Moderate Severe

   What skin problem treatment are you currently using?

C. INCREASED RISKS

1. PREGNANCY RISK
   Some research-related or animal biohazards have adverse effects on pregnancy.
   Are you pregnant or planning to become pregnant in the next year? No Yes Not Applicable

2. COMPROMISED IMMUNITY RISK
   Some research-related or animal biohazards may create an increased risk for individuals who are immunocompromised.
   Are you immunocompromised due to certain diseases (such as cancer, lupus, rheumatoid arthritis, HIV) and/or their treatment (such as steroids, radiation therapy, chemotherapy)? No Yes

3. SHEEP EXPOSURE RISK
   Exposure to sheep may create an increased risk for individuals with certain heart conditions.
   Do you have exposure to sheep AND a history of heart valve disease, heart murmur, or heart disease present from birth? No Yes

D. INJURY/ILLNESS DURING PAST 12 MONTHS

Symptoms of some research-related or animal-related illnesses may not be immediately recognized.
Please check any of the following problems you have had in the **past 12 months**:

- ☐ Chronic cough
- ☐ Abdominal cramping
- ☐ Diarrhea
- ☐ Hand/wrist pain
- ☐ Back pain/injury
- ☐ Other muscle/joint injury
- ☐ Fatigue
- ☐ Weight loss
- ☐ Fever
- ☐ Animal bite/scratch
- ☐ Infection from an animal
- ☐ Needlestick/laceration/ puncture wound
- ☐ Chemical exposure
- ☐ Other______________________________
- ☐ No injury/illness during the past 12 months

Please describe problem and treatment:

E. WORK-RELATED HEALTH CONCERNS

Do you have any work-related health concerns that you would like to discuss with an Occupational Medicine health care professional? No Yes

An Occupational Medicine health care professional will contact you to discuss these concerns.
Please indicate the best time to contact you.

To the best of my knowledge, the information included herein is true.

____ ___/___/___

Signature of Individual Completing This Form **Date**

After you submit this form, a Cornell Health Occupational Medicine health care professional will review your form and contact you within a few days if there is a need for a procedure or additional information to complete your medical surveillance requirements.