**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.