**Ithaca College Animal Care and Use Personal Health Risk Assessment Screening**

All answers contained in this questionnaire are strictly confidential and reviewed only by a healthcare provider to assess your personal risks to hazards associated with animal care and use. **EITHER** submit this form and the Health Risk Approval Form together in a sealed envelope for review at Hammond Health Center **OR** take the **Health Risk Approval form** to a health care provider of your choice**. If you visit a health care provider, only the Health Risk Approval should be returned to the college.**

**Personal Information**

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ithaca College ID: Date of Birth:\_\_\_\_\_\_\_\_

Your height: \_\_\_\_\_\_ (ft) \_\_\_\_\_ (in) Your weight: \_\_\_\_\_\_\_\_ (lbs)

**Medical History**

Please answer all questions and comment on “yes” answers in space provided below. Have you had? (Check all that apply)

\_\_\_\_\_Asthma

\_\_\_\_\_Serious Allergies

\_\_\_\_\_Bronchitis

\_\_\_\_\_Chicken pox

\_\_\_\_\_Tuberculosis (or exposure)

\_\_\_\_\_Diabetes

\_\_\_\_\_Vision problems

\_\_\_\_\_Hearing problems

\_\_\_\_\_Carpal Tunnel Syndrome

\_\_\_\_\_Musculo-skeletal problems

\_\_\_\_\_Neurological problems

\_\_\_\_\_Hepatitis A, B, or C

\_\_\_\_\_Heart Disease

\_\_\_\_\_Chest pain/pressure

\_\_\_\_\_Shortness of breath/emphysema

\_\_\_\_\_Rapid/irregular heartbeat

\_\_\_\_\_High blood pressure

\_\_\_\_\_Low blood pressure

\_\_\_\_\_Back problems/pain

\_\_\_\_\_Cancer

\_\_\_\_\_Epilepsy/seizure disorders

\_\_\_\_\_Toxoplasmosis

\_\_\_\_\_Autoimmune disorder

\_\_\_\_\_Current Pregnancy

\_\_\_\_\_Planned Pregnancy

\_\_\_\_\_Past Pregnancy

\_\_\_\_\_Miscarriage

Explanation for "Yes" to any of the above. Please provide any current treatment and level of control.

Have you been told by a physician that you have an immune compromising medical condition or are you taking medications that impair your immune system (ex. steroids, immunosuppressive drugs, or chemotherapy)? Yes No

If “Yes,” explain:

Have you had a tetanus booster in the past 10 years? (If not, we strongly recommend that you do so. Contact your physician, or ask your supervisor for help in coordinating access. Students may use Hammond Health Center.)

Yes (Year if Known: ) No Unsure

Name:

Medications: List any medications (including vitamins, inhalers, and over-the-counter) that you are currently taking:

**Allergy History**

Allergies are one of the primary hazards of working with animals in our research. These allergies can develop and increase in severity with repeated exposure. Do you have any of the following? (check all that apply)

Chronic Cough

Asthma

Chronic environmental allergies (e.g. pollen/dust)

Chronic skin problems (e.g. rashes)

Medication allergies

Food allergies

Latex allergy

Chemical allergies

Please describe:

Do you know you have these allergic reactions to:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mice | Rats | Rabbits | Birds | Cats | Dogs | Frogs |
| Sneezing |  |  |  |  |  |  |  |
| Runny or stuffy nose |  |  |  |  |  |  |  |
| Watery or itchy eyes |  |  |  |  |  |  |  |
| Coughing |  |  |  |  |  |  |  |
| Wheezing |  |  |  |  |  |  |  |
| Shortness of breath |  |  |  |  |  |  |  |
| Skin rash or hives |  |  |  |  |  |  |  |
| Difficulty swallowing |  |  |  |  |  |  |  |

Describe any other known reaction to these or to specific other species:

Are you currently taking any allergy medications? Yes No

If “Yes,” explain:

List other past major medical history (e.g. major illness, surgery):

This information is correct to the best of my knowledge. I acknowledge that if my personal health circumstances change it is my responsibility to submit an update for re-assessment.

Signature Date