

University Health Services  
910 Madison Ave, Suite 922  
Memphis, Tennessee 38163  
901-448-5630 Office  
901-448-7255 Fax

### Initial Health Questionnaire

**PART A : ( TO BE COMPLETED BY EMPLOYEE OR STUDENT WITH THE ASSISTANCE OF THE HIRING  
MANAGER OR SUPERVISOR.)**

#### Section 1.0: Occupational Exposure

##### Section 1.1: Job Information

Employee \_\_\_\_\_ Sex M  F  D.O.B \_\_\_\_\_ Date \_\_\_\_\_  
(Last, First, Middle Initial)

Address \_\_\_\_\_

Employer \_\_\_\_\_ Job title \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Employee ID Number \_\_\_\_\_

Dept. / Building \_\_\_\_\_ Room # \_\_\_\_\_

PI/Supervisor Name \_\_\_\_\_ Phone # \_\_\_\_\_

PI/Supervisor email address \_\_\_\_\_

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#### Position description: (check all that apply)

- |   |   |                                    |
|---|---|------------------------------------|
| <input type="checkbox"/> Animal Caretaker/Technician            | <input type="checkbox"/> Laboratorian /Research Associate         | <input type="checkbox"/> Visitor   |
| <input type="checkbox"/> Principle Investigator                 | <input type="checkbox"/> Researcher                               | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> IACUC Member                           | <input type="checkbox"/> Environmental Health and Safety          |                                    |
| <input type="checkbox"/> UT Police/Security                     | <input type="checkbox"/> Veterinary                               |                                    |
| <input type="checkbox"/> Custodial Services                     | <input type="checkbox"/> Facilities (HVAC, painter etc.)          |                                    |
| <input type="checkbox"/> Post doc/fellow                        | <input type="checkbox"/> Office/Administrator                     |                                    |
| <input type="checkbox"/> Student (i.e. UT, U of M, BCHS – etc.) | <input type="checkbox"/> Summer or Short Term Student <b>only</b> |                                    |

**Section 1.2: Workplace Environmental (check all that apply)**

Indicate the Workplace type(s) below that the position requires work or access to.

- RBL                       Research Laboratory                       Animal Care Facility
- Teaching Lab                       Access to all workplaces (i.e. Custodial Services, EH&S, Police)
- Office/Admin.                       Clinical labs                       Hospital/Nursing School
- Other: \_\_\_\_\_

Yes  No Does this position require access to restricted areas such as laboratories that use biological hazards or animal research laboratories in any of the workplaces indentified above? If 'YES', identify the highest biosafety level where access is required.

- BSL 1                       BSL 2                       BSL 3                       All Levels

**If any workplace boxes were checked in Section 1.2, continue to Section 1.3. If not, proceed directly to Part B, Section 3.0: Medical Health History.**

**Section 1.3: Respirator Use**

Yes  No Does this position require that you wear a respirator (does not include surgical masks)?

If YES, click here and complete the [OSHA Respirator Medical Evaluation Questionnaire](#).  
If you have completed the required OSHA Respirator Medical Evaluation questionnaire in the past, complete the Respirator [Medical Evaluation Short Form](#).

**Section 1.4: Exposure Types (Check all that apply)**

Please indicate whether this position requires work, contact or access to the following research materials or subjects by checking the applicable boxes below.

- Animals     Biological Agents
- Radiation or radioactive materials                       Chemicals or toxins
- Human Fluids, Tissue, Blood or cell lines                       Non- Human fluids, tissue, or cell line
- Teratogenic/Carcinogenic agents                       Patients
- Physical (Laser, noise, UV, Liquid N2)                       other (indicate other type here)

Comment \_\_\_\_\_

If any boxes are checked in Section 1.4, continue to Section 2.0: Risk Assessment. If not proceed directly to Part B, Section 3.0: Medical History

**Section 2.0 Risk Assessment**

**Section 2.1: Exposure to Animals**

Yes  No Does this position require contact with animals? If YES, identify the highest level and type (s) of animal species below.

ABSL 1  ABSL 2  ABSL 3  All Levels

**Rodents:**

Gerbil  Guinea pig  Hamster  
 Mice  Rat  Voles  
 Mole rats  Other \_\_\_\_\_

**Farm Animals:**

Goat  Pig  Sheep (M/F)

**Others:**

Birds  Dogs  Fish  
 Reptile/Amphibian  Macaque  Rabbits  
 Cats  Ferrets  Raccoons  
 Opossums  
 Other Non-human primate \_\_\_\_\_

**Section 2.2: Exposure to Infectious Agents**

Yes  No Does this position require work with known infectious agents? If YES, please identify the type(s) of infectious agents below

**Risk Group 3:**

Francisella tularensis  Mycobacterium tuberculosis  SARS  
 Herpes B virus  Rabies virus  Rift Valley Fever virus  
 Monkeypox virus  Yersinia pestis  Chlamydia psittaci  
 Burkholderia pseudomallei

**Risk Group 2:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Burkholderia Cepacia | <input type="checkbox"/> Chlamydia Pneumoniae  | <input type="checkbox"/> Chlamydia Trachomatis |
| <input type="checkbox"/> Hepatitis B          | <input type="checkbox"/> Japanese encephalitis | <input type="checkbox"/> Measles               |
| <input type="checkbox"/> Salmonella           | <input type="checkbox"/> AAV virus             | <input type="checkbox"/> Adenovirus            |
| <input type="checkbox"/> Lenti virus          | <input type="checkbox"/> Retrovirus            | <input type="checkbox"/> Plasmodium falciparum |
| <input type="checkbox"/> Other _____          |  |  |

**Risk Group 1:**

List \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature from the employee and supervisor or PI is **required** to ensure Part A accurately describes the applicant's job and workplace environment. This form **must** have both signatures before being seen by a University Health provider.

\_\_\_\_\_  
Employee/Applicant Name

\_\_\_\_\_  
Employee/Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor/Manager/PI

\_\_\_\_\_  
Supervisor/ Manager/ PI

\_\_\_\_\_  
Date

**PART B: TO BE COMPLETED BY EMPLOYEE**

This part is completed by the Employee or candidate holding the position identified in Section 1.1. Do not share any information from Part B of this questionnaire with anyone including managers, supervisor, PI's or human resources. After Part B is completed, the individual **MUST SIGN THE QUESTIONNAIRE**. Please submit the completed questionnaire to University Health Service's confidential fax (901) 448-7255 or email to Evelyn Lewis, Occupational Health Coordinator, [eohts@uthsc.edu](mailto:eohts@uthsc.edu).  
**(NOTE: All personal health and medical information provided in Part B is confidential and will be disclosed by UHS ONLY with the individual's written consent.)**

**Section 3.0: Medical Health History (Please answer all questions completely)**

**3.1: Personal Information**

Employee \_\_\_\_\_ Sex M  F  Date of Birth \_\_\_\_\_ Today's date \_\_\_\_\_  
(Last, First, Middle Initial)

Address \_\_\_\_\_

Employer \_\_\_\_\_ Job title \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Primary Care Provider (PCP) \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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**Section 3.2: Review of Systems and Medical Conditions**

**Do you have or have you had any of the following? (Please check all that apply)**

**Cardiovascular**

- Angina
- Heart murmur
- Congestive heart failure
- Chest pain/tightness
- Irregular heart beat
- Heart attack
- High blood pressure

**Dermatological**

- Skin rash
- Other dermatological/skin disorders

**Gastrointestinal**

- Difficulty in swallowing
- Hepatitis A
- Hepatitis C
- Liver Disease
- Hepatitis B
- Stomach/intestinal problems

**Immunological**

- Severe allergic reaction
- Compromised immune function
- Chronic stuffy nose

**Musculoskeletal**

- Arthritis
- Chronic back pain
- Joint pain and stiffness

**Neurological/Nerve**

- Loss of consciousness
- Mental problems/depression
- Seizures
- Problems with hearing
- Problems with speaking
- Stroke
- Transient Ischemic attack (TIA)

**Endocrine**

- Diabetes
- Other endocrine disorders

**Ophthalmological**

- Itchy, irritated eyes
- Problems with seeing

**Pulmonary**

- Asbestosis
- Asthma
- Bronchitis
- Chronic cough
- Emphysema/COPD
- Pneumonia
- Shortness of breath
- Tuberculosis
- Other

**Urological**

- Kidney disease
- Other urological disorders

**Section 3.3: Work Illnesses**

Yes  No Have you had an illness related to animal exposure as a result of your work?  
If YES, DESCRIBE.

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**Section 3.4: Medications (including Over-the-counter)**

List the drugs, dosage, frequency, and purpose for taking prescribed medications.

Drug	Dosage	Frequency	Purpose

**Section 3.5: Physical Limitation**

Do you have a physical condition that would impair your ability to do any of the following?

- Yes  No Stand continuously for three (3) hours
- Yes  No Refrain from eating or drinking for three (3) consecutive hours or more?
- Yes  No Do you require an accommodation for any of the items marked 'YES' above?

If YES, describe the accommodation here.

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Yes  No Are you or your partner currently pregnant or planning to become pregnant? Read the following information: "[Things you should know if you are pregnant.](#)"

**Section 3.6: Immunizations and testing history**

Check all immunization(s) received in the past:

- Tetanus  Tdap (pertussis)  Hepatitis B
- Measles  Mumps  Rubella
- Varicella (Chicken Pox)  Influenza  Rabies
- Yellow Fever  Q-Fever  BCG
- Cholera  Hepatitis A  Other \_\_\_\_\_

**Section 3.7: Tuberculosis Screening**

Yes  No Have you had a positive TB screening?

Last TB screening: (i.e. TB skin test, T spot, Quantiferon Gold, chest x-ray, TB symptom's checklist)

Date	Type of Screening	Result
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Yes  No Have you ever taken Isoniazid (INH) therapy for TB? Year \_\_\_\_\_

**Section 3.8: Allergies**

This section requests that you identify allergies to laboratory animals or other allergies such as medications, latex, peanuts, etc.

Yes  No Are you allergic to any laboratory animals? If YES, complete [the Animal Allergy Screening Form](#) and submit to Evelyn Lewis, Occupational Health Coordinator, [eohts@uthsc.edu](mailto:eohts@uthsc.edu) or fax to the confidential fax (901) 448-7255.

Yes  No Do you have any other known allergies? If YES, list the specific allergies and symptoms.

\_\_\_\_\_

**Section 3.9: Smoking History**

Yes  No Current cigarette smoker \_\_\_\_\_

Yes  No Current cigar smoker \_\_\_\_\_

Yes  No Current pipe smoker \_\_\_\_\_

Yes  No Previous smoker

How long since your last use of tobacco products? \_\_\_\_\_

**Section 3.10: Corrective Lens**

Yes  No Do you wear glasses?

Yes  No Do you wear contact lenses?

\_\_\_\_\_ Year of your last eye exam

Additional comments

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My signature below indicates that I have answered the questions above truthfully, completely, and to the best of my ability.

Email your questionnaire to Evelyn Lewis RN, COHN-S, Occupational Health Coordinator [eohts@uthsc.edu](mailto:eohts@uthsc.edu) or fax to (901) 448-7255.

\_\_\_\_\_  
Employee/Applicant Signature

\_\_\_\_\_  
Date



**Request for Occupational Health Services:**

Hepatitis B vaccine series

Hepatitis B antibody titer

Tdap

TB screening

Rabies vaccine series

Rabies antibody titer

Measles, Mumps, Rubella (MMR) vaccine

Measles antibody titer

Respirator Medical Clearance

Respirator fit test

Medical Questionnaire Review for respirator

Hearing Screening

Vision exam (lasers)

Physical Exam

General Health Panel (GHP)

Pulmonary Function Test (PFT)

Urine Drug Screen (UDS)