
OCCUPATIONAL HEALTH

WOC's should provide the following prior to placement.

1. Current Negative TB Screening.
2. Hepatitis vaccination / or titers- Immunity Status
3. Tetanus Vaccination Status
4. Rubella Vaccination Status
5. Rubeola Vaccination Status
6. Mumps Vaccination Status
7. Varicella Vaccination Status

WITHOUT COMPENSATION (WOC) APPOINTMENT
LOAD SHEET FOR PRE-PLACEMENT EVALUATION DATA
(WORKSHEET ONLY – NOT PART OF EMPLOYEE’S MEDICAL RECORD)

HRMS POC: MARY SILVA HRMS extension: (925) 372-2026

Client Information:

NAME	
ADDRESS	
CITY, STATE, ZIP CODE	
WORK PHONE	
HOME PHONE	
ALT PHONE / CELL	
M / F	
DOB	
SSN	
Proposed work station/duty location	
Proposed Position / Title	

Allergies /	Meds

INITIAL TB ASSESSMENT INFORMATION

LAST TB TEST (date- mm/day/yr)	Documentation Provided Y / N (source)
RESULTS - Positive / Negative	

TB EVALUATION REQUIREMENTS

STEP 1 (date-mm/day/yr)	
STEP 2 (date-mm/day/yr)	
TB Health Symptom Review	
CXR (date-mm/day/yr)	

IMMUNOLOGY ASSESSMENT

ITEM	Immunity Y/N	Documentation/Source	Dates (mm/day/yr)	Labs Ordered (mm/day/yr)
Hepatitis B				
Mumps				
Varicella Zoster				
Rubella				
Rubeola				

Load Information: mm/day/yr _____ Lab Notified: mm/day/yr _____

Drug Screen: Y / N Email to Linda Lew: mm/day/yr _____

Email to Physician: mm/day/yr _____ PPS1: mm/day/year _____

PPS2: mm/day/year _____

PPS3: mm/day/year _____

MEDICAL RECORD

REPORT OF MEDICAL HISTORY

DATE OF EXAM

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT (<i>Last, first, middle</i>)			2. IDENTIFICATION NUMBER	3. GRADE
4a. HOME STREET ADDRESS (<i>Street or RFD; City or Town; State; and ZIP Code</i>)			5. EXAMINING FACILITY	
4b. CITY	4c. STATE	4d. ZIP CODE		
6. PURPOSE OF EXAMINATION				

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (*Use additional pages if necessary*)

a. PRESENT HEALTH	b. CURRENT MEDICATION		REGULAR OR INTERM.
c. ALLERGIES (<i>Include insect bites/stings and common foods</i>)			
8. PATIENT'S OCCUPATION			9. ARE YOU (<i>Check one</i>)
			<input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
Tuberculosis or positive TB test				Pain or pressure in chest				Loss of finger or toe			
Blood in sputum or when coughing				Chronic cough				Painful or "trick" shoulder or elbow			
Excessive bleeding after injury or dental work				Palpitation or pounding heart				Recurrent back pain or any back injury			
Suicide attempt or plans				Heart trouble				"Trick" or locked knee			
Sleepwalking				High or low blood pressure				Foot trouble			
Wear corrective lenses				Cramps in your legs				Nerve injury			
Eye surgery to correct vision				Frequent indigestion				Paralysis (<i>including infantile</i>)			
Lack vision in either eye				Stomach, liver or intestinal trouble				Epilepsy or seizure			
Wear a hearing aid				Gall bladder trouble or gallstones				Car, train, sea or air sickness			
Stutter or stammer				Jaundice or hepatitis				Frequent trouble sleeping			
Wear a brace or back support				Broken bones				Depression or excessive worry			
Scarlet fever				Adverse reaction to medication				Loss of memory or amnesia			
Rheumatic fever				Skin diseases				Nervous trouble of any sort			
Swollen or painful joints				Tumor, growth, cyst, cancer				Periods of unconsciousness			
Frequent or severe headaches				Hernia				Parent/sibling with diabetes, cancer, stroke or heart disease			
Dizziness or fainting spells				Hemorrhoids or rectal disease				X-ray or other radiation therapy			
Eye trouble				Frequent or painful urination				Chemotherapy			
Hearing loss				Bed wetting since age 12				Asbestos or toxic chemical exposure			
Recurrent ear infections				Kidney stone or blood in urine				Plate, pin or rod in any bone			
Chronic or frequent colds				Sugar or albumin in urine				Easy fatigability			
Severe tooth or gum trouble				Sexually transmitted diseases				Been told to cut down or criticized for alcohol use			
Sinusitis				Recent gain or loss of weight				Used illegal substances			
Hay fever or allergic rhinitis				Eating disorder (anorexia bulimia, etc.)				Used tobacco			
Head injury				Arthritis, Rheumatism, or Bursitis							
Asthma				Thyroid trouble or goiter							

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions.		
c. Inability to assume certain positions.		
d. Other medical reasons (If yes, give reasons.)		
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		
15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.)		
16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		
19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)		
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.)		
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
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NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE
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**DEPARTMENT OF VETERANS AFFAIRS
VA NORTHERN CALIFORNIA HEALTH CARE SYSTEM (VANCHCS)
LATEX ALLERGY QUESTIONNAIRE**

Mather (05) Phone: (916) 843-9395 FAX: (916) 843-9394
Martinez (05) Phone: (925) 370-4007 FAX: (925) 372-2247

Name: _____	Date: _____
SSN: XXX – XX - _____	Date of Birth: _____
Department: _____	Work Phone: _____
Job Title: _____	Signature: _____

1. Have you ever been told by a physician that you have an allergy to latex products? Yes No comment: _____
2. Do you have any congenital conditions such as spina bifida, myeloma or myelodysplasia? Yes No comment: _____
3. Have you had any of the following conditions in the past?

	YES	NO	UNK		YES	NO	UNK
Contact dermatitis				Asthma			
Rhinitis				Itching			
Conjunctivitis				Autoimmune disease			
Eczema				Hayfever			

4. Do you have any drug allergies? Yes No please list: _____
5. Do you have any food allergies? Yes No Do they include any of the following:

	YES	NO	UNK		YES	NO	UNK
Avocado				Chestnut			
Passion fruit				Raw Potato			
Banana				Kiwi			
Peach				Tomato			
Papaya							

6. How many surgeries have you had in the past? _____ Please list type of surgery and your age at the time of surgery:
-

7. Have you had extensive dental work: Yes No Please list type of work:
-

8. Have you ever had an allergic reaction during anesthesia: Yes No
comment: _____
9. If your occupation involves frequent contact with latex products, what products to you have contact with? _____
10. Have you ever had an anaphylactic reaction to latex devices or products? Yes No
If yes, please describe the circumstances under which the reaction occurred: _____
11. After handling or wearing latex products, have you ever experience?

	YES	NO	UNK		YES	NO	UNK
Chapping or cracking of skin				Redness			
Runny nose/congestion				Swelling			
Itching (hands, eyes, etc.)				Hives			

12. Have you ever had a reaction to any of the following sources of latex?

	YES	NO	UNK		YES	NO	UNK
Balloons				Condoms			
Rubber gloves				Elastic undergarments			
Hot water bottles				Dental dams			
Rubber balls				Erasers			
Rubber bands				Face masks			
Adhesive tape				Foam pillows			
Dental bit blocks				Garden hoses			
Bandages				Golf grips			
Belts				Latex BP cuffs			
Brassieres				Dental masks			
Carpet backing				Pacifiers			
Clothing				Shoe wear			
Rubber cement				Tennis grip			
Suspenders				Weather stripping			
Teething rings				IV tubing			

Office Use Only:

Recommendations: _____

Education Provided: _____

Other: _____



**DEPARTMENT OF VETERANS AFFAIRS
VA NORTHERN CALIFORNIA HEALTH CARE SYSTEM (VANHCBS)
RESPIRATOR MEDICAL EVALUATION**

Last Name: _____ First Name: _____ Sex: Male Female
 Last 4 SSN: _____ Facility: _____ Dept: _____ Work #: _____
 Date: _____ Height: _____ Weight: _____ Age: _____ Job Title: _____

MEDICAL HISTORY

Has a doctor ever told you that you have any of the following?

	YES	NO		YES	NO
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to Latex	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers:

List all current medications you are taking: _____

Smoking History: Never smoked Ex-smoker Smoker

REVIEW OF SYSTEMS

	Yes	No
Are you short of breath at rest?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get short of breath while walking?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get short of breath at work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get chest pain with certain activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get chest pain at work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any medical problems you feel may interfere with wearing a respirator?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever worn a respirator before?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any problems wearing a respirator?	<input type="checkbox"/>	<input type="checkbox"/>
Do you normally have a beard, goatee, and mustache or other facial hair?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers:

Occupational Health Use Only

Approved Approved with restrictions Denied More information is needed for approval

Restrictions: _____

REVIEWED BY: _____ Date: _____



DEPARTMENT OF VETERANS AFFAIRS
VA NORTHERN CALIFORNIA HEALTH CARE SYSTEM (VANHCSS)
TB SYMPTOM SCREENING QUESTIONNAIRE

Mather (05) Phone: (916) 843-9395 FAX: (916) 843-9394
Martinez (05) Phone: (925) 370-4007 FAX: (925) 372-2247

Name: _____	Date: _____
SSN: XXX - XX - _____	Date of Birth: _____
Department: _____	Work Phone: _____
Job Title: _____	Signature: _____

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | In the last year, have you had any of the following symptoms? |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness lasting 3 weeks or more |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough lasting 3 weeks or more |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained, excessive fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained, persistent fever lasting 3 weeks or more |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained, excessive sweating at night |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained weight loss |

IF YOU ANSWERED YES TO ANY ITEM IN 1, PLEASE ANSWER THE FOLLOWING QUESTIONS.

In the last year:

- Have you been told by a health care provider that your immune system is not working right, or that you cannot fight infection?
 Yes No Don't Know
- Have you worked in a location where patients with active TB receive care or services?
 Yes No Don't Know
- Have you lived with or had close contact with someone who has TB disease?
 Yes No Don't Know
- Have you had an abnormal chest x-ray?
 Yes No Don't Know
- Have you worked, volunteered, or lived in any institution such as another medical facility, jail, group home, or homeless shelter?
 Yes No Don't Know
- Have you traveled outside the United States?
 Yes No Don't Know

HEPATITIS B VACCINE DECLINATION (Mandatory)

I understand that due to my occupational exposure to blood, or other potentially infectious materials, I may be at risk of acquiring HBV (Hepatitis B Virus) infections. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B Vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

Signature of Employee

Date

Employee currently declines Hepatitis B Vaccine pending the results of titer.

REFUSAL TO SIGN DECLINATION

_____ (Name of Employee) has been offered the Hepatitis B Vaccine on _____ (Date) and has declined vaccination at this time. The employee also chooses not to sign the Hepatitis B Vaccine Declination Form.

Signature and Title

Date

Reference: Federal Register, Vol 56, No. 235, page 64182, Friday, December 6, 1991.

VA Form 10-5549d

*U.S. GPO: 1993-343-1324/74347



DEPARTMENT OF VETERANS AFFAIRS
VA NORTHERN CALIFORNIA HEALTH CARE SYSTEM (VANCHCS)
OCCUPATIONAL HEALTH DEPARTMENT / MTZ 05

150 MUIR RD/MTZ 05
MARTINEZ, CA 94553
925-372-2247 FAX

10535 HOSPITAL WAY
MATHER, CA 95655-1200
916-843-9394 FAX

RETURN FAX TO OCCUPATIONAL HEALTH

INFLUENZA VACCINE TRACKING & DATA ENTRY FORM 2009 – 2010

PLEASE PRINT

Last name: _____ First name: _____

SS# (last 4): _____ Department / Service: _____ Date: _____

Site: Chico ___ Fairfield ___ Mare Island ___ Martinez ___ Mather ___ McClellan ___ Oakland ___ Redding ___

Work Status: VA Employee ___ VA Volunteer ___ WOC ___ Student/Intern: ___ Other: ___

*Influenza vaccine is encouraged and offered annually to all VA NCHCS healthcare workers (Current CDC recommendation) and other eligible employees and volunteers who do not have potential contraindications. **If you DECLINE this vaccination, please complete Part B of this form, otherwise, please complete part A (screening) and review the current Vaccination Information Statement, which you receive with your influenza vaccination.***

Part A: SCREENING

Potential contraindications	YES	NO
Are you currently ill and have a fever greater than 100 F?		
Have you ever had a bad reaction to the flu vaccine?		
Have you ever had a paralyzing disease called Guillain-Barre Syndrome (GBS)?		
Are you severely allergic to eggs (hives, tongue swelling, difficulty breathing)?		
Are you allergic to the preservative thimerosal?		
Are you allergic to latex?		

Part B. DECLINATION

I understand due to my occupational exposure, I may be at risk of acquiring influenza infection. In addition, I may spread influenza to my patients, other healthcare workers and my family. This can result in serious infection particularly for persons with high risk for influenza complications (see VIS). I've been given the opportunity to be vaccinated with the influenza vaccine, but at this time **DECLINE** for the below noted reason.

1, Received vaccination elsewhere: Date _____ Location: _____

2. Medically contraindicated ___ 3. Allergic ___ 4. Side Effects ___ 5. Other _____

Signature: _____

FOR OFFICE USE ONLY

_____ Afluria® CSL Biotherapies LN 07549111A Exp Jun 30,2010 0.5 ml IM R L Deltoid
VIS Date 8/11/09

Administered by (Name/Title): _____



**DEPARTMENT OF VETERANS AFFAIRS
VA NORTHERN CALIFORNIA HEALTH CARE SYSTEM (VANCHCS)
OCCUPATIONAL HEALTH DEPARTMENT / MTZ 05**

150 MUIR RD/MTZ 05
MARTINEZ, CA 94553
925-372-2247 FAX

10535 HOSPITAL WAY
MATHER, CA 95655-1200
916-843-9394 FAX

RETURN FAX TO OCCUPATIONAL HEALTH

Tetanus, Diphtheria and Pertussis (Tdap) Immunization

PLEASE PRINT CLEARLY

Last name: _____ First name: _____

SS# (last 4): _____ Department / Service: _____ Date: _____

Site: Chico _____ Fairfield _____ Mare Island _____ Martinez _____ Mather _____ McClellan _____ Oakland _____ Redding _____

Work Status: VA Employee _____ VA Volunteer _____ WOC _____ Student/Intern: _____ Other: _____

Tetanus, Diphtheria and Pertussis (Tdap) Immunization was licensed in 2005 and protects against Tetanus, Diphtheria and Whooping cough. Healthcare workers under age 65 and all adults under age 65 who have close contact with infants less than 12 months of age should receive a Tdap at least once in their adult life.

To receive the vaccination, please complete Part A (screening) and review the current Vaccination Information Statement (VIS), which you receive with your vaccination.

Part A: SCREENING

Allergies: Please List

Potential contraindications	YES	NO
Have you ever had a paralyzing disease called Guillain-Barre Syndrome (GBS)?		
Have you ever had a bad reaction to the Tetanus vaccine?		
Have you ever had a severe neurologic disorder (epilepsy, coma, stroke, encephalitis)?		
Have you ever had a severe reaction following a Tetanus shot (swelling, severe pain)		
Are you allergic to latex?		

If you **DECLINE** this vaccination, please complete Part B (declination) of this form.

Part B. DECLINATION

I understand I may be at risk of acquiring Pertussis infection. In addition, I may spread Pertussis to my patients, other healthcare workers, children and infants, and my family. This can result in serious infection particularly for under the age of 12 months (see VIS). I've been given the opportunity to be vaccinated with the Tdap vaccine, but at this time **DECLINE** for the below noted reason.

1. Received vaccination elsewhere:

Td Approximate Date _____ Location: _____
Tdap Approximate Date _____ Location: _____

2. Medically contraindicated 1. Allergic ___ 2. Side Effects ___ 3. Other ___

EMPLOYEE SIGNATURE: _____

FOR OFFICE USE ONLY

_____ Boostrix® Tdap LN _____ Exp _____ 0.5 ml IM R L Deltoid
VIS Date 11/18/08

Administered by (Name/Title): _____

Tdap 7/28/10

Animal Exposure Baseline History

DATE: _____

1. Name: _____ SSN(last 4)" _____
2. Work Location: _____
3. Work Phone Number: _____
4. Cell Number: _____
5. DOB: _____ Male Female Pregnant: Yes No
6. Service: _____ Job Title: _____
7. Extension: _____ Pager: _____ Email: _____
8. Routing Symbol: _____ Building and Room # : _____
9. Supervisor: _____ Extension: _____
10. Animal contact within VAMC (check all that apply):
Dogs Cats Non-human Primates Rabbits
Pigs Sheep Rodents Guinea Pigs Other _____
11. Total amount of contact time with animals (include contact with animal tissues, waste, body fluids, carcasses or animal quarters):
 - a. More than one hour/week
 - b. One or less hour per week
 - c. Other: _____
12. Does your work with animals involve any human or animal pathogens or infectious disease?
 - a. Yes No If yes, please explain: _____
13. If you are in contact with non-human primates:
 - a. Have you ever had Tuberculosis (Tb)? Yes No If yes, were you treated with medications, and for how long you took them? _____
 - b. Have you been vaccinated with BCG for Tb? Yes No Year _____
 - c. Have you ever had a positive reaction to a Tb skin test? Yes No
14. Are you receiving immunosuppressive therapy such as prednisone, steroids ro anti-cancer drugs
 - a. Yes No

15. How often do you wear Personal Protective Equipment (PPE) when working with animals? (Check all that apply)

Type of PPE	<u>Sometimes</u>	<u>Always</u>	<u>Never</u>	<u>Rarely</u>
Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety Glasses/Goggles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Do you smoke, eat or drink in the animal areas? Yes No

17. How often to you do the following after handling animals at work?

	<u>Sometimes</u>	<u>Always</u>	<u>Never</u>	<u>Rarely</u>
Wash hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Do you currently have, or have a history of the following conditions? (Check all that apply)?

Hay Fever Asthma Allergic Skin Problems
 Eczema Sinusitis Other Chronic Respiratory Infections

19. Has anyone in your family ever had hay fever, asthma, eczema or allergic skin conditions:

Yes No If yes, list: _____

20. Do you have sneezing spells, runny or stuffy nose, watery or itchy eyes, coughing, wheezing or shortness of breath, skin rash or hives, or difficulty swallowing after working with laboratory animals or their cages?

Yes No

21. Which animals cause the above problems? _____

22. How frequently are you bothered by the symptoms below:

Symptoms	<u>Never</u>	<u>Monthly</u>	<u>Weekly</u>	<u>Daily</u>
Watery, itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny or stuffy nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent dry cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>