BioPath: Biohazards Medical Monitoring Program
UNIVERSITY OF FLORIDA
Revised May 2011

Biohazards Medical Assessment Questionnaire

The purpose of this form is to obtain information about your personal health and work-related exposure potential. This information will be used by the UF Student Health Care Center (SHCC), Occupational Medicine Service to make an assessment of your fitness to work with biohazardous material. The SHCC will evaluate the information on this form and notify you, your supervisor, and the Biosafety Office at UF EH&S of work restrictions or extra protective measures required for your health, as well as whether you have completed all the applicable occupational health requirements needed for you to continue your work with biohazards.

Based on your answers to this questionnaire, the UF SHCC Occupational Medicine Service may request that you be seen at the SHCC Health Science Center location, room D2-49, for a medical exam prior to initiating work with certain biohazards, or on a periodic basis after that. You will be asked to complete this Biohazard Medical Assessment Questionnaire periodically to assess ongoing risks and fitness for duty.

The information captured by this form is confidential. The SHCC will not release confidential information about you without your written consent, except as required by law.

Please fill out the questionnaire below (if you print the form and complete it by hand, PRINT CLEARLY with black ink).

- **If you will handle BSL2+/BSL3 agents or will be present when agent(s) are in active use , you must contact the SHCC for a physical examination.**
- **If you are on a short-term visit and will not handle agents (short-term visitors, guests, vendors or contractors), you only need to submit the completed medical assessment questionnaire to the SHCC. However, if necessary, the SHCC will contact you for further information.**
- **Forms may be submitted by mail, confidential FAX or in-person to:**

Occupational Medicine Clinic
Student Health Care Center
University of Florida
Box 100148, Gainesville, FL 32611
D2-49 Health Science Center (Second floor of the Dental Tower)
Ph #: 352-294-5700 Fax #: 352-846-2003

Include your Name and Phone Number below in the event the SHCC needs to contact you.

Name: _____ **UFID:** _____ **Phone:** _____

PART ONE: **MEDICAL HISTORY**

1. Have you had any of the following difficulties in the past 12 months? (Check all that apply)

☐ Problem maintaining balance or consciousness (e.g. dizziness or fainting, narcolepsy, seizures or epilepsy, stroke)

☐ Mental health problems (e.g. anxiety, depression, panic attacks, schizophrenia)

☐ Shortness of breath or inability to tolerate exercise because of breathing, persistent cough, or chest pains

☐ Chemical dependency or alcohol abuse

☐ Needed emergency care or been hospitalized

☐ Other (not included above) Explain:

2. Do you have any diseases that may suppress your immune system (e.g. lupus, cancer etc.) or do you currently take medication(s) that may suppress your immune system (e.g. steroids, chemotherapy)? ☐Yes ☐No

   If yes, please list:

3. Do you have any known allergies? ☐Yes ☐No If so, what are you allergic to?

4. List all medications you take on a regular basis (including over-the-counter medications):

5. Do you have any other health conditions that you think could be adversely affected by your work with the biological agents in your lab or in a BSL3 facility? ☐Yes ☐No If yes, please list the condition(s):

6. Are you currently on any work restrictions or activity limitations? ☐Yes ☐No If yes, please describe:

7. Are you sensitive to latex? ☐Yes ☐No If yes, please describe your symptoms:

8. Have you worn a respirator before? ☐Yes ☐No If yes, describe any difficulties noted with respirator use:

9. Will you be wearing any other personal protective clothing and/or equipment (other than the respirator)? ☐Yes ☐No If yes, please describe:

10. Do you now, or have you ever, smoked tobacco? ☐Yes ☐No

Name: _____ **UFID:** _____ **Date:** _____

11. Have you had, or do you now have, any of the following? (Check all that apply)

- ☐ Lung disease
- ☐ Heart Trouble
- ☐ History of Fainting/Seizures
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Feelings of Claustrophobia (sensation of Smothering)
- ☐ Skin Problems/Abnormalities
- ☐ Heat Exhaustion/Heat Stroke
- ☐ Defective Vision
- ☐ Defective Hearing
- ☐ Asthma
- ☐ Anemia
- ☐ Epilepsy
- ☐ Back Problems

12. Describe any special or hazardous conditions you might encounter when you're using your respirator (for example, confined spaces, life-threatening gases):

13. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

14. Will you work with animals as part of your research with biohazards? ☐ Yes ☐ No
    If yes, are you enrolled in the Animal Contact Program http://www.ehs.ufl.edu/Bio/Animal/acweb.htm ?
    ☐ Yes ☐ No If yes, date of last renewal?

15. Do you have any concerns or questions about occupational health and safety issues related to your job?
    ☐ Yes ☐ No If yes, please describe below:

Name: _____ **UFID:** _____ **Date:** _____

PART TWO: **EXPOSURE ASSESSMENT**

1. Total numbers of hours in an average week that you will be working with or around biohazards:

   ☐ Less than 3 hours/week ☐ 3-10 hrs/week

   ☐ 11-24 hrs/week ☐ 25 hrs or more/week

   ☐ Occasional/Irregular/Non-scheduled (i.e. maintenance, inspections)

2. Please describe your job duties as they relate to biohazards:

3. Will you be working in a BSL3 laboratory? ☐Yes ☐No

4. Please list the agents that you may be exposed to as part of your work:

   Are any of the above agents known to have resistance to treatments or antibiotics? ☐Yes ☐No

   If yes, please describe:

5. Do you have exposure to human blood, human body fluid or unfixed human tissue: ☐Yes ☐No

6. Biological toxin use? ☐Yes ☐No If yes, specify type(s):

7. Other biohazard(s) use not listed above (list):

8. Hazardous chemicals, including disinfectants and anesthetics, use? ☐Yes ☐No

   Please list chemicals:

9. Unfixed animal tissue(s)? ☐Yes ☐No Please list type of animal that tissue is from:

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ☐Yes ☐No

11. "Personal health status may impact an individual's susceptibility to infection, ability to receive immunizations or prophylactic interventions. Therefore, all laboratory personnel and particularly women of childbearing age should be provided with information regarding immune competence and conditions that may predispose them to infection. Individuals having these conditions should be encouraged to self-identify to the institution's healthcare provider for appropriate counseling and guidance". (Ref. CDC/NIH, Biosafety in Microbiological and Biomedical Laboratories, 5th Ed, December, 2009)

Regarding the statement above, do you have questions, or wish to discuss this further with a medical provider?

☐Yes ☐No Signature _____

SIGNATURE OF PARTICIPANT (Required of ALL participants):
The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

Name: _____ **UFID:** _____ **Date:** _____