NorthShore
University HealthSystem
Medical Group

OMEGA

Corporate and Occupational Health Services

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Please be sure to complete EVERY item on questionnaire

Do not leave anything blank—N/A not an acceptable answer

The information in this questionnaire is strictly confidential and will not be released to Northwestern University or to any other agency without the explicit consent of the employee.

Initial Questionnaire Review or Follow Up Screening. (Please circle one)

Name ______________________________
Address ______________________________
____
Telephone (h) ____________ (w) ____________
Birthplace ____________ Age ____________ Date of Birth ____________

Job category: **Animal Care Worker** **Research** **Veterinary** **Clerical** **Other**
Please Circle

Please list the animals with which you will be working:

Have you ever had any reactions to animals (please list)?

Please list the agents with which you will be working: (radiation, chemicals, etc):

Please list any medication that you are using:

Please list any medication allergies:

Please list your previous hospitalizations or surgeries:

Medical review:

Do you have a history of chronic rhinitis or sinusitis, asthma, eczema, hives, skin rashes, or tongue or throat swelling, anaphylaxis or positive allergy testing?
Yes ________No_________
If yes, please provide details:

____
____
____

Do you have a history of immunosuppresssion from medication or medical conditions? Examples include HIV/AIDS, cancer, lymphoma, myeloma, chronic steroid use, organ or bone marrow transplantation, sickle cell anemia, spleen injury or other.
Yes __________No ___________
If yes, please provide details:

____
____
____

Do you have a history of heart disease, lung disease, chronic liver disease, chronic kidney disease, spleen removal? Yes_______ No_________
If yes, please provide details:

____
____
____

Are you currently experiencing:

Unexplained fatigue, weight loss or lack of energy?	Yes No
Unexplained fever, chills, night sweats, lymph node enlargement?	Yes No
Severe headaches, visual changes, hearing loss, blackouts, dizziness, weakness or numbness?	Yes No
Depression, anxiety, memory loss, irritability or uncontrolled temper?	Yes No
Shortness of breath at rest or with activity?	Yes No
Wheezing, persistent cough, sputum production or coughing up of blood?	Yes No
Unexplained chest pains, palpitations or swelling of the feet?	Yes No
Persistent nausea, vomiting, abdominal pain or diarrhea?	Yes No
Rashes, hives, angioedema, anaphylaxis or other allergic problems?	Yes No
Severe or persistent neck, back pain, muscle aches, tremors or weakness?	Yes No
Swollen and painful joints?	Yes No
Other (please list and describe):	Yes No

If you answered "Yes" to any of these questions, please provide details.

____
____
____

Have you had the following immunizations:

Tetanus/diphtheria/pertussis ________Initial series __________ Date of Booster
circle: TDaP or Td

Rabies ________Initial series __________ Date of Booster

For work with primates:

Date of last tuberculosis test (tine or mantoux): Result: Positive Negative

Females only - Are you currently pregnant, trying to become pregnant, or breastfeeding?

____

I have completed the above questionnaire honestly and completely.

_________________________ _________________

Patient Signature **Date**

OMEGA/Forms/NWU lab animal questionnaire: