Initial Health Questionnaire

This Health Questionnaire is designed to provide ROHP with the following:
(a) Information about occupational exposure and risks associated with the position identified in Section 1.1;
(b) Medical information related to your ability to safely perform the functions of the position; and
(c) A baseline medical history for ongoing medical surveillance purposes.

PART A of this Questionnaire should be completed as follows:
1) **New Hires or Job Candidates:** By Manager or Supervisor and provided to New Hire or Job Candidate to complete
2) **Existing Employees:** By existing employee with assistance of Manager or Supervisor to ensure accuracy of occupational exposure and risk.

PART B of the Questionnaire will be completed by the Employee or Candidate holding or seeking to hold the position identified in Section 1.1. Do not share any information in Part B of this questionnaire with anyone including managers, supervisors, or Human Resources. After Part B is completed, the individual MUST SIGN THE QUESTIONNAIRE.

Submission Instructions: This form can be **mailed**, **faxed** or **submitted in person**—(a) printed and filled out in pen; (b) filled out online, printing and sending **electronic by secure email** to rohp@bu.edu (c) follow instructions in option b and **fax** to 617-977-8788. THE PREFERRED METHOD IS ELECTRONIC BY SECURE EMAIL.

ADDRESS: Research Occupational Health Program (ROHP), BUMC, Evans 825, 72. E. Concord Street, Boston, MA 02118

EMAIL: rohp@bu.edu **PHONE:** 617-414-7647(ROHP) **FAX:** 617-977-8788

All personal health and medical information collected by ROHP is confidential.

PART A

To be completed by hiring manager or supervisor of new employee or candidate, or, with the assistance of manager or supervisor if position below is being performed by existing employee.

SECTION 1.0: OCCUPATIONAL EXPOSURE

SECTION 1.1: JOB INFORMATION

Employee/Candidate Name | **Dept** | **Today's Date**

Position Title | **Lab Location/Bldg/Rm #** | **Campus:** ◯ **BUMC** ◯ **CRC** ◯ **NDL**

PI/Hiring Mgr Name | **PI/Hiring Mgr Phone #** | **PI/Hiring Mgr Email**

Position Description: (Check All that Apply)

- ☐ Principal Investigator
- ☐ Animal Care Technician
- ☐ Emergency Response
- ☐ Volunteer
- ☐ Undergraduate Student
- ☐ Researcher
- ☐ IACUC Member or Staff
- ☐ Public Safety
- ☐ Visitor
- ☐ Other (Please indicate):
- ☐ Veterinary
- ☐ Environmental Health and Safety
- ☐ Environmental Services (IT, trades, facilities, etc.)
- ☐ Post-graduate/Fellow

SECTION 1.2: WORKPLACE DESCRIPTION (CHECK ALL THAT APPLY)

Please indicate the workplace type(s) below whose **primary use** best fits the type of workplace the position requires work or access to.
For example: if the position is administrative but within an animal care facility, the workplace type is Animal Care Facility.

☐ NEIDL ☐ Research Laboratory ☐ Animal Care Facility ☐ Teaching Laboratory

☐ Other (Please indicate):

Does this position require access to bio-safety or animal research laboratories in any of the workplaces identified above?
If 'YES', please identify the bio-safety level(s) where access is required below.

☐ BSL 4 ☐ BSL 3 ☐ BSL 2 ☐ BSL 1 ☐ N/A

Are you enrolled in an IBC ☐ or IACUC ☐ protocol? If so, please list the protocol #:

SECTION 1.3: WORKPLACE ENVIRONMENT (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
- ☐ Patients/Human subjects
- ☐ Class 3b or 4 laser
- ☐ Radioactive material
- ☐ High hazard chemicals
- ☐ Unfixed NHP tissue
- ☐ Recombinant (rDNA)
- ☐ MRI
- ☐ Human cells, tissue, or blood
- ☐ Unfixed tissue (Species):
- ☐ Other (Please list):
- ☐ Field studies (location)

SECTION 2.0: RISK ASSESSMENT

SECTION 2.1: EXPOSURE TO ANIMALS

YES	NO	
○	○	Does this position require contact with animals? If 'YES', please identify the type(s) of animal species below.
○	○	Rodents: Species:
○	○	Small animals (rabbits, chinchillas, guinea pigs, other):
○	○	Pigs
○	○	Fish, frogs, or other aquatics
		Other:
○	○	NHP Species—**(Bi-annual TST required if working with NHP's or Mycobacterium tuberculosis)**

SECTION 2.2: EXPOSURE TO INFECTIOUS AGENTS

YES	NO	
○	○	Does this position require work with infectious agents? If 'YES', please identify the type(s) of infectious agents below.

RISK GROUP 3:

- ☐ Francisella tularensis
- ☐ Mycobacterium tuberculosis Erdman
- ☐ Mycobacterium tuberculosis H37Rv
- ☐ Japanese encephalitis virus

RISK GROUP 2:

- ☐ Burkholderia cepacia
- ☐ Chlamydia trachomatis
- ☐ Clostridium Difficile
- ☐ Cryptosporidium parvum
- ☐ Dengue virus
- ☐ Entamoeba histolytica
- ☐ Enterovirus 71 (Sarawak serotype b)
- ☐ Escherichia coli (EHEC strain)
- ☐ Haemophilus influenzae
- ☐ Herpes B virus
- ☐ Human immunodeficiency virus
- ☐ Influenza
- ☐ Japanese encephalitis virus vaccine strain
- ☐ Klebsiella pneumoniae
- ☐ La Cross virus
- ☐ Measles virus
- ☐ Methicillin-Resistant Staphylococcus aureus
- ☐ Mumps virus
- ☐ Mycobacterium bovis BCG
- ☐ Neisseria gonorrhoea
- ☐ Neisseria meningitidis
- ☐ Plasmodium falciparum
- ☐ Polio virus
- ☐ Rabies virus
- ☐ Salmonella typhimurium
- ☐ Streptococcus pyogenes (Group A)
- ☐ Vaccinia virus (Western Reserve)
- ☐ Vancomycin-Resistant enterococci
- ☐ Vibrio cholera Pacini (strain N16961)
- ☐ Yellow fever virus vaccine strain
- ☐ Yersinia enterocolitica
- ☐ Zika Virus:
- ☐ Other:

PART B

TO BE COMPLETED BY EMPLOYEE OR JOB CANDIDATE Please answer all questions completely

SECTION 3.0: MEDICAL HEALTH HISTORY

SECTION 3.1: PERSONAL INFORMATION

Full Name | Sex: ○ M ○ F | Date of Birth

Home Address

Employer: ○ BU ○ BMC | BU/BMC ID # | Email

Home phone | Work phone | Cell phone

Emergency Contact | Relationship | Phone #

SECTION 3.2: REVIEW OF SYSTEMS

Allergy and Respiratory System Health History

YES	NO	
○	○	Asthma or other chronic respiratory disease.
○	○	Allergic skin reactions such as hives, rash, or itching. If yes, please explain:
○	○	Skin conditions such as eczema, psoriasis, dermatitis.
○	○	Known or suspected animal allergies. Please check off any animal-related reaction(s): ☐ Runny/stuffy nose ☐ Sneezing ☐ Coughing ☐ Wheezing ☐ Chest tightness ☐ Shortness of breath ☐ Hives ☐ Skin rash ☐ Throat swelling If yes, please list animal(s):
○	○	Known or suspected allergies to chemicals, latex, food, or environment. If yes, please list:
○	○	Are you currently using respiratory protection or a mask?
○	○	If yes, have you been fit-tested? Please list type or respirator/mask you are using:

Immune/Metabolic System Health History

YES	NO	
○	○	Chronic health conditions such as diabetes
○	○	Valvular heart disease
○	○	Reproductive health counseling available – Would you like to speak with an occupational health provider?
○	○	Kidney or liver disease
○	○	History of spleen problems or absence of spleen
○	○	Immune system deficiencies or other limitations to your ability to fight off disease or infection (i.e., cancer, lupus, organ transplant, HIV infection, chronic infections, take oral steroids, anti-TNF medications). If yes, please list:
○	○	Do you have any questions concerning your health as it relates to the workplace that you would like to discuss with an occupational health professional? If yes, an ROHP clinician will be contacting you.

SECTION 3.2: IMMUNIZATIONS

Please submit a copy of your immunization records if available.

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

Employee/Candidate Signature **Date**

SECTION 4.0: IMPORTANT INFORMATION

Federal law prohibits employers from requesting genetic information of an employee or an employee's family member unless an exception applies. "Genetic information" includes your family medical history, the results of your or your family member's genetic tests, and the fact that you or your family member sought or received genetic services. Please do not provide such information when completing this questionnaire. Additional information is available at: www.bu.edu/eoo/federal-and-state-laws/federal.

The medical records created as a result of services performed by the health care professionals employed or contracted by the Boston University Research Occupational Health Program (ROHP) are the property of Boston University. Occupational Environmental Health Network, Inc. (OEHN) is contracted by Boston University to provide medical services as part of the ROHP. Your medical records will be maintained by OEHN on behalf of Boston University. Your consent will be requested when medical records are needed by other medical institutions to perform diagnostic tests or examinations related to fitness for duty or medical surveillance. Certain disclosures of your medical records such as records relating to drug and alcohol treatment, mental health, AIDS/HIV, and genetic testing require written authorization by you. Prior authorizations for disclosing such records may be withdrawn by written request.

Past medical records may have been created as a result of services performed by health care professionals employed by or contracted by Working Well, formerly known as Occupational Environmental Medicine (OEM) department of the Boston Medical Center, related to and during the term of your employment with Boston University or the Boston Medical Center. These medical records are currently maintained by Working Well and are the property of the Boston Medical Center. As historical medical records are an important consideration in the performance of medical surveillance, evaluations, and provision of appropriate medical care, it is important for the health care professionals at ROHP to be able to review these records maintained by Working Well. Likewise, it is important for ROHP health care professionals to be able to review medical records concerning you that were created by and are retained at Boston University's Charles River Occupational Health Center.

SECTION 5.0: CONSENT FOR EXAMINATION AND DISCLOSURE

I hereby authorize the health care professionals employed or contracted by the Boston University Research Occupational Health Program (ROHP) to examine me and maintain medical records created as a result of such medical examination. This authorization includes:

(a) Permission to review health information maintained by Boston Medical Center Occupational & Environmental Medicine and by Boston University's Charles River Occupational Health Center.

(b) Permission to obtain routine diagnostic tests, if necessary, to provide me with any immunizations which may be required.

(c) Permission to examine and treat me for occupational injuries or occupational exposure incidents..

(d) If required for my job, permission to perform an initial physical examination, a drug test, and a mental and behavioral health screening (collectively, the "Screenings") to assess my fitness for the position and to conduct any required annual or periodic Screenings, which may occur at scheduled or random times.

I hereby authorize the health care professionals employed or contracted by the Boston University ROHP to provide a comprehensive report relating to my fitness for duty to those at Boston University who have a legitimate need to know such information. I understand that such a report may include information on my medical history, medical conditions, and, if required for my job, Screening results to the extent this information is relevant to an assessment of my fitness for the position. I acknowledge that my health information may also be released to others for purposes of treatment, payment, or health care operations and for other purposes as required or permitted by workers compensation law or other applicable law. I understand that I may request a copy of my medical record by submitting a written request.

Employee/Candidate Signature **Date**

FOR CLINIC USE

ROHP Health Care Provider Signature: _____ **Date:** _____

Provider Notes: _____