Please complete this form along with form A
(Health Risk Assessment Evaluation Questionnaire)

Mail or deliver all forms to:
Concentra Medical Center
4205 Franklin Avenue, Waco, Texas 76710
To protect your privacy, please put all forms in a sealed envelope.

Medical History Questionnaire

Purpose: Employees working with research animals or entering a Baylor University animal facility are required to complete this questionnaire to identify applicable health and safety recommendations. Your answers are confidential. The purpose of the following questions is to determine if you have any special health needs to work safely with animals. A common health risk includes allergies or respiratory sensitivities which may be caused or aggravated by work around animals. Chronic health conditions, pregnancy or immune system deficiencies may increase risk of infection from animals (zoonotic diseases) or infectious agents used in animals. Chemical exposure from treated animals may also present additional risks during pregnancy or for certain respiratory or chronic health disorders.

Based on your answers, medical recommendations will be provided to reduce risk of undesirable health effects and may include wearing personal protective equipment or modifying work procedures. In some cases, a further medical evaluation may be indicated.

Instruction: Please complete this form and sign below. You must also complete form A. To protect your privacy, please put both forms in a sealed envelope and either mail or deliver both forms to **Concentra Medical Center.** Receipt of both forms is required to get medical clearance to work with or around research animals.

Name (Please Print): Date of Birth:

Gender: ☐ male ☐ female SSN - Last 4 Numbers only:

1. List all animals you will be working with:
2. Date of last Tetanus booster:
3. If you will be working with human blood/tissues/cells/cell lines/in animals:
   (a) Have you received a Hepatitis B vaccination series? Yes ☐ No ☐
   (b) **If yes:** List dates and attach vaccination record:
   (c) If post vaccination titer was done, list date:
   (d) result (attach record):
4. **Do you have any of the following medical conditions?**

Allergy and Respiratory Health History

Yes	**No**	
☐	☐	Asthma or other chronic respiratory Disease

☐ ☐ Skin conditions such as eczema, psoriasis, dermatitis

☐ ☐ Allergic skin reactions such as hives, rash, itching? If yes explain:

☐ ☐ Known or suspected allergies. Circle any animal related reaction(s): runny/stuffy nose, itching eyes, sneezing, coughing, wheezing, chest tightness, shortness of breath, hives, skin rash, throat swelling. **If yes, list animal(s):**

☐ ☐ Known or suspected allergies to chemicals, latex, food or environment?
If yes, please list:

☐ ☐ Are you currently using a respiratory protection or mask?

☐ ☐ If yes, have you been fit tested?
List the type of respirator/ mask you are using:

Immune/Metabolic System Health History

Yes No

☐ ☐ Chronic health conditions such as diabetes?

☐ ☐ Kidney or liver disease?

☐ ☐ Valvular heart disease

☐ ☐ History of spleen problems

☐ ☐ Pregnant or planning to become pregnant

☐ ☐ Immune system deficiencies or other limitations to your ability to fight off disease or infection (for example cancer, lupus, organ transplant, HIV infection, chronic infections)

If yes, please list:

☐ ☐ Current medication or treatment that may suppress your immune system (for example: high dose steroids, prednisone, cancer therapy, radiation therapy)

If yes, please list:

Authorization to Disclose Protected Health Information:

_____ _____

Employee/Participant Signature **Date**