



**SAINT LOUIS
UNIVERSITY™**

— EST. 1818 —

O H P

Institutional Occupational Health Program

I N S T R U C T I O N S

Print all information.

Complete the packet without leaving blanks. Put NO or not applicable (N/A) if needed.

After completing the packet, please return it to Employee Health.

This can be done one of three ways.

1. Interoffice mail – Employee Health – Hospital West Pavilion Suite 116
2. Secure confidential fax – 314-268-5490
3. Scan to employeehealth@slu.edu

After reviewing your responses, Employee Health may contact you to discuss the need for further medical evaluation.

If you would like further medical evaluation at any time related to potential work exposures, contact Employee Health.

For any questions about the Institutional Occupational Health program, contact Employee Health at 314-268-5499.

Saint Louis University
Institutional Occupational Health Program
Background

Regulatory and funding agencies require that Saint Louis University offer an Occupational Health Program (OHP). Each person listed on an Animal Use Protocol approved by the Institutional Animal Care and Use Committee (IACUC) must be informed about the OHP and be afforded the opportunity to participate. Prior to approval of an animal use protocol, IACUC must be able to confirm that each person listed on the protocol has been offered the OHP.

The OHP program centers around four things:

1. Medical history evaluation.
 - a. Participants are asked to complete this questionnaire to obtain information about personal health as it relates to potential work exposure to biological pathogens, recombinant DNA, and/or laboratory animals.
 - b. The OHP medical questionnaire is completed by each participant by following the INSTRUCTIONS on cover page of this OHP Medical Questionnaire.
 - c. The OHP medical questionnaire is reviewed by Employee Health with attention to animal allergies, ergonomics, and immune suppression issues.
 - d. This questionnaire may be completed at the time of hire, if work starts on a new protocol, or at intervals while working on an existing protocol.
 - e. This information will become part of the individual's Employee Health record. This will NOT become part of a SLU personnel record, a SLUCare medical record, or a hospital medical record.
 - f. Instructions for returning documentation to Employee Health are listed on page two of the form.
2. Tetanus immunization every 10 years. Employee Health will advise each participant should an update be needed.
3. Tuberculosis screening. Employee Health will advise each participant should an update be needed.
4. Evaluation of work related injuries and illnesses.
 - a. Should a work-related injury or illness occur related to this project, the involved employee should report it immediately to their supervisor and an Employee Report of Injury form should be completed.
 - b. The supervisor should phone ahead to advise either Employee Health or SLU Hospital Emergency Room of the incident and incoming exposed patient.
 - c. The injured employee should be referred to:
Employee Health
SLU Hospital - West Pavilion – 3655 Vista Avenue – Suite 116
Hours: 7:30 am to 3:30 PM - Monday – Friday - excluding holidays.
 - d. If the work-related injury or illness occurs outside business hours or if the work-related injury is severe, the injured employee should report to the Emergency Room at SLU Hospital. If the initial treatment occurs in the ER, the injured employee MUST follow up with Employee Health on the next working day. An original Employee Report of Injury form must be provided to Employee Health at the time of evaluation.

EMPLOYEE HEALTH

providing work related healthcare services for employees of Saint Louis University and SSM Health Saint Louis University Hospital

REGISTRATION INFORMATION

NAME _____ Date _____

SSM University Other _____

OCCUPATION _____

DEPARTMENT _____ SHIFT _____

SUPERVISOR _____ SUPERVISOR PHONE _____

SOCIAL SECURITY NUMBER _____ -- _____ -- _____

BIRTHDATE _____ -- _____ -- _____ AGE _____ SEX FEMALE MALE

MARITAL STATUS single married Religious preference (optional) _____

HOME ADDRESS _____

_____ ZIP _____

HOME PHONE _____ WORK PHONE _____

PAGER # _____ CELL # _____

BIRTH COUNTRY _____ # OF YEARS IN THE U.S. _____

CURRENT MEDICATIONS _____

ALLERGIES _____

LAST TETANUS SHOT _____



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SSMHealth
Saint Louis University Hospital

EMPLOYEE HEALTH

3655 Vista Ave., West Pavilion Suite 116
St. Louis, MO 63110-2539

p | (314) 268-5499

f | (314) 268-5490

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	YES	NO	Mark YES to medical conditions that you have now or have had in the past. Mark NO to medical conditions you have never had. Make a mark for each question. Per regulations, we cannot accept lines drawn down the NO column.
1			Chickenpox disease in the past
2			Fatigue
3			Allergic Reactions
4			Rashes
5			Skin diseases/Dermatitis
6			Scars
7			Identifying Marks
8			Hives/Chronic Itching
9			Glove Powder Reaction
10			Watery Eyes
11			Nasal Congestion
12			Wheezing
13			Reactions to Animals
14			Latex Reaction
15			Head Injury/Skull Fracture
16			Headaches-chronic/frequent
17			Memory Trouble
18			Epilepsy/Seizures/Convulsions/Fits
19			Mental Trouble
20			Concussion
21			Fainting/Lightheadedness
22			Dizzy/Balance Trouble
23			Loss of Consciousness
24			Stroke
25			Paralysis
26			Thinking Trouble
27			Sleep Disorder
28			Glasses and/or Contacts
29			Blindness
30			Color Blindness
31			Glaucoma
32			Cataracts
33			Eye Disease/Eye Trouble
34			Decreased Hearing
35			Draining Ear
36			Ringling in the Ears
37			Ruptured Eardrum
38			Hearing Aid
39			Hay Fever/Allergies
40			Frequent Sore Throats

	YES	NO	Mark YES to medical conditions that you have now or have had in the past. Mark NO to medical conditions you have never had. Make a mark for each question. Per regulations, we cannot accept lines drawn down the NO column.
41			Sinus Trouble
42			Tonsillectomy +/- Adenoids
43			Tuberculosis Disease
44			Positive PPD Previously Documented
45			BCG Vaccination
46			INH Therapy in the Past
47			Chronic Cough
48			Coughing Up Blood
49			Weight Loss Unexplained
50			Night Sweats
51			Fever Unexplained
52			Chest Pain
53			Current Smoker
54			Previous Smoker
55			Never Smoker
56			Pneumonia
57			Asthma/Wheezing
58			Emphysema/COPD
59			Chronic Bronchitis
60			Shortness of Breath
61			Respirator Use in Past
62			Collapsed Lung
63			Heart Trouble
64			Heart Attack/Artery Block
65			Palpitations
66			Heart Valve Trouble
67			High Blood Pressure/Hypertension
68			Low Blood Pressure
69			Carotid Artery Disease
70			Ulcer
71			Indigestion/Stomach Trouble
72			Gallbladder disease
73			Appendicitis
74			Liver Disease/Jaundice
75			Hepatitis A
76			Hepatitis B
78			Hepatitis C
79			Diabetes
80			Pancreas Disease
81			Thyroid Disease
82			Weight Gain
83			Blood in Stools
84			Kidney Disease/Kidney Stones
85			Hemorrhoids
86			Constipation
87			Hernia
88			Blood/Infection of Urine
89			Neck(cervical spine) injury/strain/pain/fracture/surgery
90			Thoracic spine injury/strain/pain/fracture/surgery

	YES	NO	Mark YES to medical conditions that you have now or have had in the past. Mark NO to medical conditions you have never had. Make a mark for each question. Per regulations, we cannot accept lines drawn down the NO column.
91			Lumbar (low back) spine injury/strain/pain/fracture/surgery
92			Finger/Hand/Wrist injury/strain/pain/fracture/surgery
93			Elbow injury/strain/pain/fracture/surgery
94			Shoulder injury/strain/pain/fracture/surgery
95			Toe/Foot/Ankle injury/strain/pain/fracture/surgery
96			Knee injury/strain/pain/fracture/surgery
97			Hip injury/strain/pain/fracture/surgery
98			Arthritis/Rheumatism/Joint pain/swelling
99			Swelling legs/ankles
100			Varicose Veins/Leg Ulcers
101			Gout
102			Amputation/Deformity
103			Cancer/Tumor
104			Anemia/Bleeding/Bruises
105			Blood disease/Leukemia
106			Gynecological Disease/Surgery
107			Prostate Disease/Surgery
108			Surgeries/operations
109			Hospitalizations
110			Fear of Heights
111			Fear of Small Places
112			Prior Military Service
113			Rejected for Military Service
114			Rejected for Life Insurance
115			Rejected for Employment
116			Drink Alcoholic Beverages
117			Recreational Drug Use
118			Smokeless Tobacco Product Use
119			Do you have any abnormal/decreased sensation/numbness/tingling in the fingers/hands/wrists/forearms?
120			Are you presently under the care of a physician?
121			Do you have any previous work-related injury?

Patient Signature

Date



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SSMHealth
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Laboratory Animal Exposure History

- _____ Animal Protocol number(s) for this OHP enrollment if known
- Yes No **Have you ever worked with laboratory animals?**
- _____ (months) **How many months have you worked with laboratory animals?**
- Check the boxes below if you have been in contact with animals and specify contact hours/day, total duration, months at SLU.**

ANIMAL	Previously	Currently	Never	Contact Hours/Day	Total Months	Months At SLU
Rats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Rabbits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Guinea Pigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Old World Monkeys (Baboon, Macaque, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
New World Monkeys (Squirrel, Marmoset, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cattle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hamsters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Gerbils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prairie Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sheep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Goats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Swine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

If other, please specify: _____

- Yes No **Do you think that you are allergic to any of these animals?**
If yes, please check all that apply:
 Rats Mice Rabbits Guinea Pigs Monkeys Cattle
 Dogs Cats Hamsters Gerbils Prairie Dogs Dogs
 Sheep Goats Swine Other (specify) _____
- Yes No **Have you ever had any problems working around animals?**
If yes, please explain: _____
- Yes No **Do you currently experience problems working around animals?**
If yes, please explain: _____
- Yes No **Do you have any of the following symptoms when working with animals?**
If yes, please check all that apply:
 Hand rash Other rash Itchy eyes Watery eyes Runny nose Scratchy throat
 Cough Wheezing Trouble breathing Other (specify) _____
- Do you use or wear any of the following items when working with animals?**
Protective Eyewear Yes Sometimes No
Mask Yes Sometimes No
Respirator Yes Sometimes No
Lab Coat Yes Sometimes No
Gloves Yes Sometimes No
- Are any agents of the following hazardous groups used in these animals?**
 Infectious Teratogenic/Carcinogenic Radioactive Other: _____

Please list if checked: _____

Allergy History

11. Yes No **Have you ever been skin tested for allergies?**

If yes, what substances were you found to be allergic to or sensitized to?

Ragweed Grass Trees Mold Mice

Dust Cat Dog Other: _____

12. Yes No **Have you ever received allergy (desensitization/immunotherapy) shots?**

If yes, what year did you receive the shots? _____

13. Yes No **Do any of your blood relatives (grandparents, parents, brothers/sisters) have allergies or asthma?**

14. Yes No **Are you allergic to latex?**

If yes, please describe your symptoms. _____

15. Yes No **Do you have any indoor pets?**

If yes, which animals and for how long?

Animal	1-2 Years	2-3 Years	3-4 Years	Over 4 Years
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Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other (Type): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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16. **What type of fuel do you use at home?**

Cooking: Electricity Gas/propane Oil Wood Other _____

Heating: Electricity Gas/propane Oil Wood Other _____

17. Yes No **Do you have roaches in your home?**

18. Yes No **Do you have non-pet mice or other animals in your home?**

Recombinant DNA Pre-Exposure Screening

19. Yes No **Are you involved with recombinant DNA technology or microorganisms that contain recombinant DNA?**

20. Yes No **Does the research involve techniques in which viable, recombinant DNA-containing microorganisms are used to infect animals that require Bio-safety level 2 or 3 containment?**

If yes, please explain: _____

21. Yes No **Do you have any diseases (lupus, cancer, etc.) that suppress your immune system?**

If yes, please describe your symptoms. _____

22. Yes No **Do you currently take any medications that may suppress your immune system?**

If yes, please describe your symptoms. _____

23. Yes No **Do you have any other health conditions that you think could be adversely affected by your work?**

If yes, please describe your symptoms. _____

24. Other Comments: _____

Attestation and Signature

There may be increased occupational health risks associated with your job if situations change. At any time after completing this questionnaire, you are strongly encouraged to contact Employee Health to receive occupational health counseling/evaluation, 1)if you become pregnant or if you start planning to become pregnant, 2)if you become aware of a change in your health status, 3)if the species of animal that you are exposed to at work changes

Signature: _____ Date: ____--____--____

Instructions to Submit

Return completed form to Employee Health. It is best to use our secure confidential fax: 314-268-5490. You can keep the original for your own records after you check the fax confirmation from your machine. Alternatively, the form can be interoffice mailed to Employee Health. It is still recommended that you keep a copy for your own records. Finally, form can be scanned and e-mailed to: employeehealth@slu.edu