

University Health and Counseling Service
Division of Student Affairs

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Health Service Occupational Health Medical History

Demographic Information:

Name: _____
Last First Middle
(If changed, please give previous name: _____)

Employee ID: _____ CWRU Network ID (ie: abc12) _____

Date of Birth: _____ Gender: Male Female Other
MM/DD/YYYY

Position: _____ Department: _____ Supervisor: _____

Status: Faculty
 Staff
 Graduate Student
 Undergraduate Student
 Outside Contractor
 Volunteer

Medical History:

Past Medical History (chronic conditions, significant illnesses):

Past Surgical History (procedure, approximate dates):

Medications taken regularly:

Do you have an immune-compromising medical condition or are you taking medication that may impair your immune system? Yes No

Certain pre-existing medical conditions can place an individual at greater risk of illness or injury in the animal care setting. Disclosure is not required, however you may want to exclude yourself from working

in the animal environment if you believe you may be at risk. Consult with your physician if you have concerns regarding the following conditions:

Cancer

Pregnancy

Allergic Condition

Immunosuppressive drug therapy

Organ or tissue transplant recipient

Congenital immunodeficiency

Acquired immunodeficiency

Allergies:

Medications: _____ Reaction (rash, breathing difficulty etc): _____

Animals (specify): _____ Reaction (rash, breathing difficulty etc): _____

Food, insects, environmental: _____

Have you had or do you now have (check any that apply):

- | | | | |
|---|--|---|--|
| <input type="radio"/> Asthma | <input type="radio"/> Eczema/Dermatitis | <input type="radio"/> Breathing Problems | |
| <input type="radio"/> Seizures | <input type="radio"/> Heart Disease | <input type="radio"/> Muscular Dystrophies | <input type="radio"/> Diabetes |
| <input type="radio"/> Bone/Joint Pain | <input type="radio"/> Arthritis | <input type="radio"/> Chronic Back Pain | <input type="radio"/> Varicose Veins |
| <input type="radio"/> High blood Pressure | <input type="radio"/> Cancer | <input type="radio"/> Black out spells | <input type="radio"/> Stroke |
| <input type="radio"/> Loss of vision | <input type="radio"/> Amputation | <input type="radio"/> Blood Clots | <input type="radio"/> Circulation Problems |
| <input type="radio"/> Bleeding Problems | <input type="radio"/> Tuberculosis | <input type="radio"/> Neurological Problems | <input type="radio"/> Immune Disease |
| <input type="radio"/> Parkinson's Disease | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Disability/Rehab | <input type="radio"/> Hepatitis/Jaundice |

Immunizations:

Check if you have received the following immunizations:

- | | |
|---|------------------------|
| <input type="radio"/> Tetanus Booster | Date: _____ |
| <input type="radio"/> MMR (Measles, Mumps, Rubella) | Date: _____ |
| <input type="radio"/> Rabies (series of 3) | Dates: _____ |
| <input type="radio"/> Rabies Titer | Date and result: _____ |
| <input type="radio"/> Hepatitis B (series of 3) | Dates: _____ |

Do you use tobacco? Yes No If yes, what type and how often? _____

Prior Work Environment:

Have you ever had an on the job injury? Yes No

If yes, Date: _____ Place: _____

Explain: _____

Have you ever worked with (check all that apply):

Carcinogens Asbestos Radio-active Material Radiation producing Equipment

If yes, Dates: _____ Place: _____

Explain: _____

CWRU Work Environment:

What are your duties? _____

Will you be:

Lifting >50lbs: Yes No

Working with chemicals: Yes No

Type of chemical(s): _____

Working with patients: Yes No

Hours per week: _____

Location: _____

Handling Experimental Animals: Yes No

Hours per week: _____

Species of animal(s):

- Mouse Rat Pig Rabbit Frog Dog Guinea Pig
- Sheep Toad Zebrafish Cat Chicken Fishes
- Woodchuck Ferret Goat Hamster Salamander Shrew (musk)

Working with human cell/tissue: Yes No

Working with radiation: Yes No

Picking up biohazard waste: Yes No

Working with infectious agents: Yes No

Type of infectious agent: _____

Do you understand all of these questions? Yes No

University Health & Counseling clinicians are available to discuss workplace health concerns not covered by this questionnaire.

I have completed this form and I certify that the information given is true.

Signature Date

FOR UHS USE ONLY:

Form reviewed by: _____ Date: _____

Actions taken: _____