GWUMC ARF OCCUPATIONAL HEALTH QUESTIONNAIRE

The answers to this questionnaire will help Employee Health Services (EHS) medical providers determine your risk for occupational illness. Your answers are seen only by EHS and are treated with the utmost privacy. You may consult with an EHS provider if you have questions about any part of this questionnaire. Please drop off, mail or fax the completed form to the Employee Health Service for review. Contact information is in the footer of this form.

Name: _____ DOB:_____ / _____ / _____

Address: _____

E-mail : _____ Phone: _____

1) Have you previously been evaluated for occupational conditions as a worker in the ARF? ❑ Yes ❑ No

   If Yes, which of the following apply (more than one may apply)

   - ❑ This is an annual re-evaluation
   - ❑ My work conditions or exposures have changed
   - ❑ I have new symptoms of allergies
   - ❑ There have been changes in my health status
   - ❑ I am pregnant or trying to become pregnant
   - ❑ Other (explain) _____

2) Are you taking any of the following medications?

   Asthma inhalers or other asthma medications ❑ Yes ❑ No

   Antihistamines or other allergy medications ❑ Yes ❑ No

   Steroids ❑ Yes ❑ No

   If Yes to any, please list your medications: _____

3) Are you allergic to any medications? ❑ Yes ❑ No

   If Yes, please list your medication allergies: _____

4) Have you ever had skin rashes, itching of the lips or throat, breathing problems or a severe allergic reaction after handling, eating or being exposed to any of the following?

   Gloves, latex or vinyl ❑ Yes ❑ No

   Band-aids ❑ Yes ❑ No

   Rubber or elastic bands or rubber handles ❑ Yes ❑ No

   Balloons, condoms or other rubber products ❑ Yes ❑ No

   Any of the following foods (if yes, please circle) ❑ Yes ❑ No

Avocado	Apple	Pear	Celery
Carrot	Hazelnut	Kiwi	Papaya
Pineapple	Peach	Cherry	Plum
Apricot	Banana	Melon	Chestnut
Nectarine	Grape	Fig	Passion Fruit
Tomato	Potato		

Risk Factors for Latex and other Occupational Allergies

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5) Do you now or have ever had of any of the following medical conditions?

Risk Factors for Latex and other Occupational Allergies

Allergic Rhinitis ("hay fever", "seasonal allergies")	❑ Yes	❑ No
Allergic Conjunctivitis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Eczema	❑ Yes	❑ No
Hives	❑ Yes	❑ No
Spina Bifida	❑ Yes	❑ No
Severe allergic reaction or anaphylaxis	❑ Yes	❑ No

If Yes to any, what was the cause? _____ ❑ Not Known

Risk factors for some pathogen exposures

HIV infection or AIDS	❑ Yes	❑ No
Cancer undergoing current chemotherapy or x-ray therapy	❑ Yes	❑ No
Any chronic condition requiring steroids or other medications that suppress your immune system	❑ Yes	❑ No

If Yes, please list: _____

Any other condition causing a weakened immune system ❑ Yes ❑ No

If Yes, please list: _____

6) Do you have any of the following symptoms?

Symptoms of allergic reactions and asthma

Sneezing	❑ Yes	❑ No
Runny nose	❑ Yes	❑ No
Itchy nose, throat or ears	❑ Yes	❑ No
Chest tightness	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No
Cough	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No
Rash, itching, cracking, chapping, scaling, or weeping of the skin from glove use	❑ Yes	❑ No

7) Are you pregnant or do you plan to become pregnant while working in the ARF? ❑ Yes ❑ No ❑ Does not apply

8) Has it been 10 years or more since your last tetanus booster? ❑ Yes ❑ No

9) Will you be working with tuberculosis or animals infected with TB? ❑ Yes ❑ No

10) Is there anything else you believe is important or would like to discuss with the medical provider? If so, detail below or speak with the provider.

_____

_____

_____

Completed by: _____ Date: _____
Employee/Investigator/Student

Reviewed by: _____ Date: _____
Provider

Thank you. We will contact you if further information is needed or you need to be seen in the EHS. Recommendations follow on the next page. Recommendation copies to file, patient and ARF.

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