UTSA STUDENT/VOLUNTEER MEDICAL SURVEILLANCE INITIATIVE
Animal Allergy Questionnaire

Last Name	First Name	Middle Name	Date of Birth

Department	Supervisor/PI	Job Title

Work Phone	Cell Phone	E-mail

Animal Contact ☐ Yes ☐ No if No, skip to next section - Allergy History

Indicate the types of animal contact you will have:

☐ Direct contact and handling of animals
☐ Direct contact and handling of non-fixed or non-sterilized animal tissues, animal fluids, or animal wastes
☐ Direct contact with non-sanitized animal caging or enclosures
☐ Services, repair, or maintenance related support of animal equipment, devices, and/or facilities

Do you have contact with animals outside of work? ☐ Yes ☐ No
If yes, please list the species_____

Do you have any of the following symptoms that you feel may cause or make worse, or are the result of working at an animal facility or with lab animals? ☐ Yes ☐ No

☐ Watery, burning, or itchy eyes ☐ Runny nose ☐ Sneezing ☐ Shortness of breath
☐ Cough ☐ Chest tightness ☐ Wheezing ☐ Hives ☐ Rash

Have you ever changed jobs/work habits because of symptoms from handling animals? ☐ Yes ☐ No

Allergy History

Indicate any allergic conditions you may have to the following:

☐ Dog ☐ Cat ☐ Farm Animals ☐ Bird (feathers) ☐ Sheep (wool) ☐ Nonhuman Primates
☐ Rabbit ☐ Swine ☐ Rats or mice ☐ Guinea Pigs ☐ Mold ☐ Weeds
☐ Latex ☐ Grasses ☐ Trees ☐ Wood ☐ Chemicals_____
☐ Other_____ ☐ Medications

Indicate any medical conditions you may have:

☐ Skin rash ☐ Hay fever ☐ Chronic coughing ☐ Eczema ☐ Latex allergy ☐ Asthma
☐ Allergic conjunctivitis (itchy, watery eyes from allergies)
☐ Chronic allergies (food, pollens, dust, or chemicals)
☐ Allergic rhinitis (runny nose due to allergies)
☐ A natural parent or sibling with allergies to animals or their substances

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Medical History (check if yes)	Yourself	Immediate Family (optional)
Respiratory allergies including hay fever	☐	☐
Asthma	☐	☐
Skin Allergies	☐	☐
Food Allergies	☐	☐
Chronic sinus disease	☐	☐
Smoker or tobacco user	☐	☐

Comments – please list any concerns or other health-related information the Occupational Health physician should know:

_____
_____
_____

I have answered this form truthfully and to the best of my recollection.

_____ _____
Signature Date

Physical Examination

To be completed by OHP Physician/staff

☐ Required; OHP staff will arrange for a physical examination

☐ Not required

Physician Comments

_____
_____
_____
_____

_____ _____
Physician Signature Date

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