Cornell University
Animal Users Health and Safety Program

AUHSP MEDICAL EVALUATION FORM

INSTRUCTIONS:	Please complete all applicable sections, sign the form, and return to: Occupational Medicine, Cornell Health, 110 Ho Plaza, Ithaca, NY 14853-3101 FAX: 607-255-6149 For assistance, call 607-255-6960.

Name (*last, first, middle initial*) _____ **Cornell ID #** _____

Preferred contact phone # (*with area code*) _____ **Email address** _____

Facility where research/animal exposure occurs _____ **PI or Supervisor** _____

A. TETANUS IMMUNIZATION

What is the year of your last tetanus immunization? _____
[The CDC and New York State Department of Health recommend tetanus immunization every 10 years.]

B. ALLERGIES / ASTHMA / SKIN PROBLEMS

1. Are you allergic to any animals? ☐ No ☐ Yes ☐ Don't know
   If yes, please list the animal(s) and their associated allergy symptoms: _____

   Have you had these animal allergy symptoms within the past 12 months? ☐ No ☐ Yes
   If yes, what is the current severity of your animal allergy symptoms? ☐ Mild ☐ Moderate ☐ Severe

   What animal allergy treatment are you currently using? _____

2. Are you allergic to any environmental allergens such as grass, trees, pollen, dust? ☐ No ☐ Yes ☐ Don't know
   If yes, please list environmental allergens and their associated allergy symptoms: _____

   Have you had these environmental allergy symptoms within the past 12 months? ☐ No ☐ Yes
   If yes, what is the current severity of your environmental allergy symptoms? ☐ Mild ☐ Moderate ☐ Severe

   What environmental allergy treatment are you currently using? _____

3. Do you have asthma? ☐ No ☐ Yes ☐ Don't know
   If yes, please describe your asthma triggers (if known): _____

   Have you had asthma symptoms within the past 12 months? ☐ No ☐ Yes
   If yes, what is the current severity of your asthma symptoms? ☐ Mild ☐ Moderate ☐ Severe

   What asthma treatment are you currently using? _____

4. Do you have allergy or asthma symptoms specifically related to your work? ☐ No ☐ Yes ☐ Don't know
   If yes, please describe your allergy or asthma symptoms at work: _____

   Have you had these symptoms within the past 12 months? ☐ No ☐ Yes
   If yes, what is the current severity of these symptoms? ☐ Mild ☐ Moderate ☐ Severe

   What treatment are you currently using for your work-related allergy or asthma symptoms? _____

5. Have you had any skin problems caused or exacerbated by your work activities? ☐ No ☐ Yes ☐ Don't know
   If yes, please describe the skin problem: _____

   _____

   Have you had this skin problem within the past 12 months? ☐ No ☐ Yes
   If yes, what is the current severity of your skin problem? ☐ Mild ☐ Moderate ☐ Severe

   What skin problem treatment are you currently using? _____

   _____

C. INCREASED RISKS

1. Pregnancy risk
   Some research-related or animal biohazards have adverse effects on pregnancy.
   Are you pregnant or planning to become pregnant in the next year? ☐ No ☐ Yes ☐ Not applicable

2. Compromised immunity risk
   Some research-related or animal biohazards may create an increased risk for individuals who are immunocompromised.
   Are you immunocompromised due to certain diseases (such as cancer, lupus, rheumatoid arthritis, HIV) and/or their treatment (such as steroids, radiation therapy, chemotherapy)? ☐ No ☐ Yes

3. Sheep exposure risk
   Exposure to sheep in a research and/or teaching environment (not including clinicial veterinary activities) may create an increased risk for individuals with certain heart conditions.
   Do you have exposure to sheep in a research and/or teaching environment AND a history of heart valve disease, heart murmur, or heart disease present from birth? ☐ No ☐ Yes

D. INJURY/ILLNESS DURING PAST 12 MONTHS

Symptoms of some research-related or animal-related illnesses may not be immediately recognized.
Please check any of the following problems you have had in the **past 12 months**:

☐ Chronic cough	☐ Other muscle/joint injury	☐ Infection from an animal
☐ Abdominal cramping	☐ Fatigue	☐ Needlestick/laceration/ puncture wound
☐ Diarrhea	☐ Weight loss	☐ Chemical exposure
☐ Hand/wrist pain	☐ Fever	☐ Other_____
☐ Back pain/injury	☐ Animal bite/scratch	☐ No injury/illness during the past 12 months

Please describe problem(s) and treatment: _____

_____

_____

E. OTHER HEALTH CONCERNS

Do you have any health concerns (including heart-related issues, allergies, or any conditions that may affect your immune system) that might be impacted by work with animals that you would like to discuss with an Occupational Medicine health care professional? ☐ No ☐ Yes

If so, a Cornell Health Occupational Medicine health care professional will contact you to discuss these concerns.
Please indicate the best days/times to contact you: _____

F. SIGNATURE

To the best of my knowledge, the information I have provided on this form is true.

Signature _____ **Date** _____

NOTE: A Cornell Health Occupational Medicine health care professional will review your form. If there is a need for a procedure or additional information to complete your medical surveillance requirements, we will contact you within a few days.