

Participant Submitting the Health Questionnaire Form

Submitting a Health Questionnaire Form

After completing a Risk Assessment, participants will be directed to the Health Questionnaire (HQ), which they must complete and submit. The HQ is routed to a Medical Professional for review. Participants will be notified if their HQ is approved or requires further action.

Key Points

- **Confidentiality:** The PI or Supervisor does not have access to the Health Questionnaire.
- **Reusability:** The HQ is completed once and reused for multiple Risk Assessments.
- **Time Limit:** Participants have **30 minutes** to complete the HQ. Ensure access to your medical information during this process.

Note: Include vaccination history, including dates, when filling out the HQ. This information does not auto-populate from prior records. Missing or incomplete vaccine details may delay clearance and require unnecessary appointments.

Health Questionnaire Content

The HQ provides Medical Professionals with a participant's medical history, including:

- Vaccines
- Tuberculosis Screening
- General Health History
- Exposures
- Biological Hazards
- Allergies
- Prescription Medications
- Health Status Changes

Health Questionnaire Form

Participant: [REDACTED]

By completing this form, I hereby authorize the UCI COEH (Center for Occupational and Environmental Health) to exchange, receive, and discuss medical information pertinent to my care concerning the use of animals and/or insects, including potential zoonotic risks, in research with the UCR EH&S Occupational Health Division. I further acknowledge this form is required and must be updated and resubmitted either every 3 years or at an interval determined by Occupational Health and/or the overseeing occupational health physician. When filling out your confidential Health Questionnaire (HQ), make sure to have your vaccination history available. Vaccine history, including date, is requested on the HQ and does not automatically pre-populate from previous forms or previous vaccination and/or testing services performed by Occupational Health. If you have had a vaccination, but it is not entered on the questionnaire or "I don't know" is marked, the Occupational Health Physician may recommend this service before providing clearance. This may create an unnecessary appointment or clearance delay.

Date of Birth (MM/DD/YYYY)

Vaccines

- | | | |
|--|--|--|
| Have you previously received the full dose of Hepatitis B immunization series? | <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> I don't know | If yes, the estimated completed date: <input type="text"/> (MM/YYYY) |
| Have you had the Tetanus vaccine? | <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> I don't know | If yes, the estimated completed date: <input type="text"/> (MM/YYYY) |
| Have you had the Rabies vaccine? | <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> I don't know | If yes, the estimated completed date: <input type="text"/> (MM/YYYY) |
| Have you had a Rabies titer? | <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> I don't know | If yes, the estimated completed date: <input type="text"/> (MM/YYYY) |

General History

- Arthritis, Chronic Pain or Joint Pain? Yes No
If yes, please explain:
- Do these conditions interfere with your work? Yes No
If yes, please explain:
- Immune system compromised condition? Yes No
If yes, please explain:
- Have you been diagnosed with a heart or lung disease that would interfere with your ability to wear a respirator? Yes No

Exposures

Are you or will you be wearing a respirator at work? If uncertain, review the risk assessment and contact your supervisor.

Yes No

If yes, please select the type of respirator:

Dust Mask N-95 Surgical Mask 1/2 Face Full Face PAPR

Do you wear protective goggles or protective clothing at work?

Yes No

If yes, protection from what agent or action?

If you work in noisy or loud environments, is hearing protection readily available for your own comfort at work?

Yes No N/A

If working with needles, do you know how to report a needle stick injury?

Yes No N/A

If you work in extreme environmental conditions have you been trained on how to protect yourself?

Yes No N/A

Biological Hazards

If your work requires you to work with human blood, tissue, or body fluids, have you been offered a Hep B vaccine through Occupational Health Services and completed Blood Borne Pathogens training?

Yes No N/A

- I need to have a blood test (Hepatitis B titer) to document immunity.
- I would like to receive a Hepatitis B vaccine.
- I have declined to receive Hepatitis B vaccine and have signed a declination form at the time of the training.

Would you like to speak to a physician about any of your workplace exposures?

Yes No

Allergies

Please indicate which symptoms you have experienced:

- | | | |
|---|---|--|
| <input type="checkbox"/> Chronic Cough | <input checked="" type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Itchy, Irritated Eyes (Conjunctivitis) |
| <input type="checkbox"/> Hay Fever (Dust) | <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> Chronic Allergies (Food, Pollens, Dust) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Itchy, Runny Nose (rhinitis) |
| <input type="checkbox"/> Chest Tightness or Shortness of Breath | | |

Are these allergies more frequent at work? Yes No N/A

Please indicate which animals or substances cause you symptoms:

- | | | |
|--|--|---|
| <input type="checkbox"/> Alfalfa | <input type="checkbox"/> Bird (Feathers) | <input type="checkbox"/> Cat |
| <input checked="" type="checkbox"/> Cattle | <input type="checkbox"/> Chemicals | <input type="checkbox"/> Dog |
| <input checked="" type="checkbox"/> Goat | <input type="checkbox"/> Grasses | <input type="checkbox"/> Guinea Pig |
| <input type="checkbox"/> Horse | <input type="checkbox"/> Latex | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Primates | <input type="checkbox"/> Rabbit | <input type="checkbox"/> Rat or Mice |
| <input type="checkbox"/> Sheep (Wool) | <input type="checkbox"/> Swine | <input type="checkbox"/> Trees |
| <input type="checkbox"/> Weeds | <input type="checkbox"/> Wood | <input type="checkbox"/> Other (e.g. chemicals, food, environment): |

Do your allergies require treatment? Yes No N/A

Have you had to wear a respirator, goggles or protective clothing to protect yourself from allergies? Yes No

Have you been given an alternative to using latex gloves? Yes No

Are you being treated by your private doctor for allergies or asthma? Yes No

Prescription Medications

Are you currently taking any prescription medications? Yes No

If yes, please list separated by commas (e.g. Prilosec, Advair):

Has your health status changed in the last year? Yes No

If yes, describe:

Reproductive Health

Are you pregnant? Yes No N/A

Would you like to have a "Reproductive Health Consult" with an Health Physician? Yes No

Note: Saving this Health Questionnaire Form will create a new OHSS process with a copy of the following Risk Assessment.

Save Health Questionnaire Form

Cancel

Completing the Health Questionnaire

- Automatic Redirection:** Participants will be directed to the HQ after agreeing to the Risk Assessment.
 - If you opt to complete it later, access it via **Pending Actions** on the homepage.

Welcome, [Redacted]

My Assessments

Pending Actions



2. Review or Modify Existing HQ:

- If an HQ is already on file, you can:
 - Approve it with no changes.
 - Modify it if your health status has changed by clicking the **Update** button.

My Assessments

= Action Required

Supervisor	RA	HQ	MA	Process Completed	Renewal Date
[Redacted]	08/07/2024 - A	08/29/2024 - C	11/27/2024 - CR	--	--
[Redacted]	04/30/2024 - A	08/12/2024 - C	08/29/2024 - C	08/29/2024	08/29/2027
[Redacted]	04/18/2024 - A	04/18/2024 - C	04/18/2024 - C	04/18/2024	04/18/2027

04/18/2024 - A	<div style="border: 1px solid #ccc; padding: 5px; display: inline-block;"> View  Update</div>	04/18
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3. **Save and Submit:** Once completed, click **Save Health Questionnaire** to submit it.

<div style="display: inline-block; background-color: #0056b3; color: white; padding: 5px 15px; border-radius: 3px;">Save Health Questionnaire Form</div> <div style="display: inline-block; border: 1px solid #ccc; padding: 5px 15px; margin-left: 10px;">Cancel</div>
