BEFORE YOU START TYPING INTO THIS FORM:
1. SAVE A COPY ("SAVE AS") TO YOUR COMPUTER 2.FILL OUT SAVED VERSION OF THE FORM USING ACROBAT READER . FAILURE TO FOLLOW THESE STEPS MAY RESULT IN A LOSS OF DATA ENTERED.

UF BioPath: Biohazards Health Assessment Questionnaire

The purpose of this health assessment questionnaire is to obtain information about your personal health status and work-related exposure potential. This information will be evaluated only by health care providers. They will assess your "fitness for work" with Risk Group 3(RG3) biohazardous material and determine if any specific work restrictions or extra protective measures are required for your health.

Resubmit this form annually and/or if there are changes in personal health status or exposure risks. The information captured by this form is confidential.

Please fill out the questionnaire below.

Your Name: **UF ID number:** **Cellphone #:**

1. Can you read English? Yes☐ No☐

☐ ☐

2. **DOB:** **Gender at birth:** ☐**M** ☐**F** **Height:** **(ft)** **(in)** **Weight:** **(lbs)**

PART ONE: **MEDICAL HISTORY**

3. Have you had any of the following difficulties in the past 12 months? (Check all that apply)

☐ Problem maintaining balance or consciousness (e.g. dizziness or fainting, narcolepsy, seizures or epilepsy, stroke)

☐ Mental health problems (e.g. anxiety, depression, panic attacks, schizophrenia)

☐ Shortness of breath or inability to tolerate exercise because of breathing, persistent cough, or chest pains

☐ Chemical/alcohol dependency

☐ Needed emergency care or been hospitalized

If yes, explain:

Other (not included above), explain:

4. Do you have any diseases that may suppress your immune system (e.g. lupus, cancer etc.)☐ Yes ☐No
   If yes, explain:

5. Do you currently take medication(s) that may suppress your immune system
   (e.g. steroids, chemotherapy)?☐Yes ☐No
   If yes, please list:

Name: **UF ID number:** **Cellphone #:**

6. Do you have any known allergies? ☐ Yes ☐ No

If so, what are you allergic to?

7. List all medications you take on a regular basis (including over-the-counter medications):

8. Do you have any other health conditions that you think could be adversely affected by your work with the biological agents in your lab or in a BSL3 facility? ☐ Yes ☐ No
   If yes, please list the condition(s):

9. Are you currently on any work restrictions or activity limitations? ☐ Yes ☐ No
   If yes, please describe:

10. Are you sensitive to latex? ☐ Yes ☐ No
    If yes, please describe your symptoms:

11. Have you had, or do you now have, any of the following? (Check all that apply and add a brief explanation)

- ☐ History of Fainting
- ☐ Skin Problems/Abnormalities
- ☐ Heat Exhaustion/Heat Stroke
- ☐ Defective Vision
- ☐ Defective Hearing
- ☐ Anemia
- ☐ Epilepsy
- ☐ Back Problems
- ☐ Immune Suppression

12. Will you be wearing any other personal protective clothing and/or equipment other than the respirator?

☐ Yes ☐ No

If yes, please describe:

PART TWO: **RESPIRATOR USE**

13. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and wellbeing of others (for example: rescue, security):

Name: **UF ID number:** **Cellphone #:**

14. Select the type and characteristics of the respirator you will use. *(Please **check all that apply**)*

Disposable, Non-cartridge Type Filtering Face Piece including R or P versions: N95 ☐ N99☐ N100☐

Tight fitting Half☐or Full Face Piece☐ Powered Air-purifying Respirator (PAPR) with hood ☐

15. Have you worn a respirator in the past?
Yes☐ No☐
If yes, please describe:

16. Do you exercise? Yes☐ No ☐

If "yes," describe activity and frequency:

17. Level of physical exertion while wearing respirator generally experienced: Mild ☐ Moderate☐ Strenuous☐
18. Maximum amount of time you wear a respirator in a single day: Hours per day
19. Have you had the following problems while using a respirator?

Eye irritation	Yes ☐ No ☐	General weakness or fatigue	Yes ☐ No ☐
Skin allergies or rashes	Yes ☐ No ☐	Other problem that interferes with use of a respirator	Yes ☐ No ☐
Anxiety	Yes ☐ No ☐		

If yes to any, please explain:

20. Describe any special or hazardous conditions you might encounter when you're using your respirator (for example, confined spaces, life-threatening gases):

21. **Tobacco Usage:**
Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ No☐
If "yes", how many packs per day? ½ or less ☐ 1 ☐ 2 ☐ > 2 packs ☐
How many years have you smoked? 1-9 ☐ 10-19 ☐ 20-29 ☐ 30+☐

22. **Conditions:**

Have you **ever** had any of the following conditions:	Yes	No		Yes	No
Seizures (fits)	☐	☐	Claustrophobia (fear of closed-in places)	☐	☐
Diabetes (sugar disease)	☐	☐	Trouble smelling odors	☐	☐
Allergic reactions that interfere with your breathing	☐	☐			

If yes to any, please explain:

23. **Medications:**

Do you currently take medications for any of the following:	Yes	No		Yes	No
Breathing or lung problems	☐	☐	Blood Pressure	☐	☐
Heart trouble	☐	☐	Seizure (fits)	☐	☐

Name: **UF ID number:** **Cellphone #:**

24. Cardiovascular or heart symptoms: Have you ever had any of the following problems:

	Yes	No		Yes	No
Heart attack	☐	☐	Heart arrhythmia (heart beating irregularly)	☐	☐
Stroke	☐	☐	High blood pressure	☐	☐
Heart Failure	☐	☐	Any other heart problem that you have been told about	☐	☐
Swelling in your legs not caused by walking	☐	☐	Angina	☐	☐
Frequent pain or tightness in chest	☐	☐	Skipping/missing heartbeat (in the last 2 years)	☐	☐
Pain or tightness in your chest during physical activity	☐	☐	Heartburn-like symptoms not related to eating	☐	☐
Pain or tightness in your chest that interferes with your job	☐	☐	Any other heart/circulatory symptoms	☐	☐

If yes, please explain:

25. Pulmonary or lung problems:

Have you **ever** had any of the following conditions:

	Yes	No		Yes	No
Asbestosis	☐	☐	Silicosis	☐	☐
Asthma	☐	☐	Pneumothorax (collapsed lung)	☐	☐
Chronic bronchitis	☐	☐	Broken ribs	☐	☐
Emphysema	☐	☐	Any chest injuries or surgeries	☐	☐
Pneumonia	☐	☐			
Tuberculosis	☐	☐			
Any other lung problem that you've been told about If yes, please explain:	☐	☐			

26. Pulmonary or lung illness symptoms:

Have you ever had any of the following symptoms:

	Yes	No		Yes	No
Shortness of breath	☐	☐	Shortness of breath that interferes with your job	☐	☐
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	☐	☐	Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
Shortness of breath when washing or dressing yourself	☐	☐	Have to stop for breath when walking at your own pace on level ground	☐	☐
Coughing that produces phlegm (thick sputum)	☐	☐	Coughing that wakes you early in the morning	☐	☐
Coughing that occurs mostly when you are lying down	☐	☐	Coughing up blood in the last month	☐	☐
Wheezing	☐	☐	Chest pain when you breathe deeply	☐	☐
Wheezing that interferes with your job	☐	☐	Any other symptoms that you think may be related to lung problems	☐	☐

PART THREE: **EXPOSURE ASSESSMENT**

27. Will you work with animals as part of your research with RG3 biohazards? Yes ☐ No ☐
    If yes, are you enrolled in the Animal Contact Program http://www.ehs.ufl.edu/Bio/Animal/?
    Yes ☐ No ☐ If yes, date of last renewal?

28. Do you have any concerns or questions about occupational health and safety issues related to your job? Yes ☐ No ☐
    If yes, please describe below:

Name: **UF ID number:** **Cellphone #:**

29. Total numbers of hours in an average week that you will be working with or around RG3 biohazards:

☐ Less than 3 hours/week ☐ 3-10 hrs/week
☐ 11-24 hrs/week ☐ 25 hrs or more/week
☐ Occasional/Irregular/Non-scheduled (i.e. maintenance, inspections)

30. Please describe your job duties as they relate to RG3 biohazards:

31. Please list all the biological agents that you work *directly* with as part of your work:

32. Please list all the biological agents that you may be *indirectly* exposed to as part of your work:

33. Are any of the above agents known to have resistance to treatments or antibiotics?If yes, please describe: Yes ☐ No ☐ Don't know ☐

34. Do you have exposure to human blood, human body fluid or unfixed human tissue: Yes ☐ No ☐

35. Will you be in direct contact with Biological Toxins? Yes ☐ No ☐
If yes, specify toxin type(s):

36. Any use of hazardous chemicals, including disinfectants and anesthetics? Yes ☐ No ☐
Please list chemicals:

37. Unfixed animal tissue(s)? Yes ☐ No ☐
If yes, Please list type of animal that tissue is from:

38. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes ☐ No ☐

39. Has your employer told you how to contact the health care professional who will review this? Yes ☐ No ☐

SIGNATURE OF PARTICIPANT (Required of ALL BioPath participants):

The above information is accurate and complete to the best of my knowledge.

Signature:_____ Date:_____

Participant: Please refer to Clinic Authorization form for specific instructions depending if you are a new enrollee or will be renewing.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

TO BE COMPLETED BY THE LICENSED HEALTH CARE EXAMINER:

Employee Name: **UF ID:** **DOB:**

The Biohazard Medical Monitoring Form has been reviewed ☐ Yes ☐ No

BioPath Health questionnaire has been reviewed ☐ Yes ☐ No

This individual has been found to be physically able to use the following respirator

Single use, filter mask (four attachment points, e.g. N95) ☐

Half-faced cartridge-type, negative pressure ☐

Full-faced cartridge-type respirator, negative pressure ☐

Hood/helmet powered cartridge-type (PAPR) ☐

This respirator clearance expires in : ☐ 1 ☐ 2 ☐ 3 years from the date below

Restrictions/Limitations for respirator use (if applicable):

There is insufficient information to make determination at this time ☐

☐ Fit For Duty

☐ Not Fit for Duty

☐ Fit for Duty with Restriction(s)

☐ Follow up Due 1 yr

Other Interval (list)

Notes/Comments:

Reviewer's Name (print) Reviewers Signature Date: