

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 ADOBE ADOBE 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 from the UF Occupational Medicine (OCCMED) Clinic. 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. The OCCMED Clinic will not release confidential information about you without your written consent, except as required by law.

Please save as, then fill out the questionnaire below. This form must be completed and submitted electronically - the OCCMED Clinic will not accept hand written forms.

Contact the OCCMED Clinic at 352-294-5700 with questions on how to complete this form.

Your Name:

UF ID number:

Cellphone #:

1. Can you read English? Yes No

2. Has the [Payment Authorization](#) Form been submitted? Yes No

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

PART ONE: MEDICAL HISTORY

4. 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:

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

6. 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 #:

7. Do you have any known allergies? Yes No

If so, what are you allergic to?

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

9. 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):

10. Are you currently on any work restrictions or activity limitations? Yes No

If yes, please describe:

11. 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
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Skin allergies or rashes	Yes	No	Other problem that interferes with	Yes	No
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Anxiety	Yes	No	use of a respirator		
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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
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Seizures (fits)			Claustrophobia (fear of closed-in places)		
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Diabetes (sugar disease)			Trouble smelling odors		
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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
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Breathing or lung problems			Blood Pressure		
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Heart trouble			Seizure (fits)		
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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
Stroke
Heart Failure
Swelling in your legs not caused by walking
Frequent pain or tightness in chest
Pain or tightness in your chest during physical activity
Pain or tightness in your chest that interferes with your job

Heart arrhythmia (heart beating irregularly)
High blood pressure
Any other heart problem that you have been told about
Angina
Skipping/missing heartbeat (in the last 2 years)
Heartburn-like symptoms not related to eating
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
Asthma
Chronic bronchitis
Emphysema
Pneumonia
Tuberculosis

Silicosis
Pneumothorax (collapsed lung)
Broken ribs
Any chest injuries or surgeries

Any other lung problem that you've been told about If yes, please explain:

26. Pulmonary or lung illness symptoms:

Yes No

Yes No

Have you ever had any of the following symptoms:

Shortness of breath
Shortness of breath when walking fast on level ground or walking up a slight hill/incline
Shortness of breath when washing or dressing yourself

Coughing that produces phlegm (thick sputum)
Coughing that occurs mostly when you are lying down
Wheezing
Wheezing that interferes with your job

Shortness of breath that interferes with your job
Shortness of breath when walking with other people at an ordinary pace on level ground
Have to stop for breath when walking at your own pace on level ground
Coughing that wakes you early in the morning
Coughing up blood in the last month
Chest pain when you breathe deeply
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: [click here to submit](#) form via an e-mail attachment or email to OccMedClinic-RiskAssessment@ahc.ufl.edu

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/REVIEWER:

Individual's Name:

UF ID:

DOB:

The BioPath questionnaire has been reviewed Yes ☐ No ☐

This individual has been found to be physically able to use the following respirator (*check all that apply*):

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: