

Health History Form

Community Care Physicians

OCCUPATIONAL HEALTH SERVICES

Rensselaer Technology Park, 101 Jordan Rd., North Greenbush, NY 12180

(518) 274-9126

Fax (518) 274-9487

Annual Health History

Research Animal Users



If you are associated with the University at Albany and have a NetID, you may log in via the link at the top of this page and submit this form electronically. Your name and email address will then be filled in automatically. **If you do not have a NetID, you will need to fill this form out and then print and fax it to the number at the top of the form.**

Error rendering macro 'hidden-field-macro'

Hidden fields must be provided with a value

Name required

Examinee Email Address: required

Principal Investigator: required

Assign:

Choose One Rodents Fish/Frogs Field Studies Other

Details:

1. Have you worked with animals before?

Choose One Yes No

Details:

2. Do you have pets?

Choose One Yes No

3. Do any of your close personal contacts (family, friends, significant others) work with animals, or do they have pets?

Choose One Yes No

4. Have you, to your knowledge, ever had an illness as a result of exposure to animals?

Choose One Yes No

5. Have you had asthma?

Choose One Yes No

5a. Do you take asthma medications?

Choose One Yes No

If you are using a "rescue" inhaler, how often have you used it in the last month?

5b. Have you been hospitalized or been seen in the emergency room because of asthma in the last five years?

Choose One Yes No

5c. Have you taken steroids (prednisone) for asthma in the last five years?

Choose One Yes No



6. Have you had any of the following symptoms, not associated with a cold or flu, in the last 5 years?

Watery, Itchy eyes:

Never Monthly Weekly Daily

Runny, stuffy, nose:

Never Monthly Weekly Daily

Post-nasal drip:

Never Monthly Weekly Daily

Sneezing spells:

Never Monthly Weekly Daily

Frequent dry cough:

Never Monthly Weekly Daily

Wheezing in chest:

Never Monthly Weekly Daily

Skin rash:

Never Monthly Weekly Daily

Hives:

Never Monthly Weekly Daily

Swelling of the throat:

Never Monthly Weekly Daily

6a. Do you take medications for any of these symptoms?

Choose One Yes No

7. Have you ever been treated by a doctor for allergies?

Choose One Yes No

8. Have you identified what substances of exposures trigger your symptoms?

Choose One Yes No

9. Do you take other medication?

Choose One Yes No

9a. List other medications:

10. Do you have other health issues?

Choose One Yes No

10a. List other health issues:

11. When was your last tetanus booster? required

12. HIPAA Authorization required

Choose One Yes

I have read and understand the attached HIPAA form and authorize Community Care Physicians, P.C. to use and/or disclose certain protected health information (PHI) about me to the Research Compliance Officer, Adrienne D. Bonilla, and my Principal Investigator.



HIPAA Release SU...-13 Revised.docx



Disclaimer

I understand that by submitting this form, the information entered into this form will be transmitted via email over the Internet which may not be secure. If this is unacceptable to me, I can instead print out the form and fax it to the number at the top of the form.