### AUHSP Medical Evaluation Form

**INSTRUCTIONS:** Please complete all applicable sections, sign the form, and return to:  
Occupational Medicine Office, Gannett Health Services, 110 Ho Plaza, Ithaca, NY 14853-3101  
Contact Gannett’s Occupational Medicine Department at 607-255-6960 for assistance.

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.)</th>
<th>Cornell ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred contact phone number (include area code)</td>
<td>E-mail address</td>
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<tr>
<td>Facility where research/animal exposure occurs</td>
<td>PI or Supervisor</td>
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### A. TETANUS IMMUNIZATION
What is the year of your last tetanus immunization?  
(CDC and New York State Dept of Health recommend tetanus immunization every 10 years.)

### B. ALLERGIES/ASTHMA/SKIN PROBLEMS

1. Are you allergic to any animal(s)?
   - **If yes,** please list the animal(s) and their associated allergy symptoms

   Have you had these animal allergy symptoms within the past 12 months?  
   - **If yes,** what is the current severity of your animal allergy symptoms?  
   - What animal allergy treatment are you currently using?

2. Are you allergic to any environmental allergens such as grass, trees, pollen, dust?  
   - **If yes,** please list environmental allergens and their associated allergy symptoms

   Have you had these environmental allergy symptoms within the past 12 months?  
   - **If yes,** what is the current severity of your environmental allergy symptoms?  
   - What environmental allergy treatment are you currently using?

3. Do you have asthma?  
   - **If yes,** please describe your asthma triggers (if known)

   Have you had asthma symptoms within the past 12 months?  
   - **If yes,** what is the current severity of your asthma symptoms?  
   - What asthma treatment are you currently using?

4. Do you have allergy or asthma symptoms specifically related to your work?  
   - **If yes,** please describe your allergy or asthma symptoms at work

   Have you had these symptoms within the past 12 months?  
   - **If yes,** what is the current severity of these symptoms?  
   - 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 may create an increased risk for individuals with certain heart conditions.
   Do you have exposure to sheep 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 and treatment: ____________________________________________

E. WORK-RELATED HEALTH CONCERNS

   Do you have any work-related health concerns that you would like to discuss with an Occupational Medicine health care professional?  
   □ No  □ Yes

   A Gannett Occupational Medicine health care professional will contact you to discuss these concerns. Please indicate the best time to contact you.

   ________________________________   ________________________________
   Signature of Individual Completing This Form   Date

To the best of my knowledge, the information included herein is true.

   ________________________________   __/__/___
   Signature of Individual Completing This Form   Date

After you submit this form, a Gannett Occupational Medicine health care professional will review your form and contact you within a few days if there is a need for a procedure or additional information to complete your medical surveillance requirements.

04/11