This CONFIDENTIAL medical history form must be completed when an individual is first listed on an Animal Use Protocol or AUP (**initial** **enrollment)** and at the time of AUP renewal (i.e., triennial renewal every three years), **unless specified by the IACUC** (i.e., on an annual basis). **However, if at any time there is a change in your personal health (e.g., pregnancy, illness, immunodeficiency), you must update and re-submit this form for evaluation by the Occupational Health Program.**

NOTE: This page is for review by UCR office personnel. For assistance, please email [iacuctraining@ucr.edu](mailto:vetmail@ucr.edu)

|  |  |
| --- | --- |
| Your name(first and last) | Your role (check one) |
| your response | Faculty  Staff  Student  Post-doc |
|  | |
| PI’s name(first and last) | AUP number |
| your response | your response |

**Select one:**

|  |
| --- |
| New enrollment *(first time filling out this UC form; please fill out all sections of the entire form)* |
| Triennial renewal *(I’ve filled out the UCR form before)*  Are you still working on the AUP indicated on this form?  Yes *(fill out the entire form, sign, and submit to the Office of Research Integrity (ORI)*  No *(only a signature is required; please sign and submit the form to ORI).* |

**I authorize release of immunization history and rabies titer (if required) results to the UCR IACUC to be used for monitoring in regard to the Occupational Health Program at the University of California, Riverside.**

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:

*(Name may be typed if this form is emailed to iacuctraining@ucr.edu from your UCR email account)*

This page is for review by a medical professional

# About You

|  |  |  |
| --- | --- | --- |
| Name (first and last) | Date of birth (mm/dd/yyyy) | Gender |
| your response | your response | Male  Female  Other; specify |

# Exposure

|  |  |
| --- | --- |
| Animals or animal tissues you are currently, or will be, exposed to (at work or outside of work e.g. pets, livestock) | |
| Animal types |  |
| Frequency and duration of exposure | your response |
|  | |
| Carcinogens, infectious agents, or hazardous substances you have been, or will be, exposed to | |
| Substances | your response |
| Frequency and duration of exposure | your response |

# Medical History

|  |  |  |
| --- | --- | --- |
| Symptoms you are currently experiencing (check all that apply) | | |
| Itchy eyes | Wheezing | Chest tightness |
| Coughing | Runny nose | Skin rash |
|  | | |
| Conditions you have experienced in the past (check all that apply) | | |
| Medication allergy/sensitivity | Insect/animal/plant allergies | Hay fever |
| Food allergy/sensitivity | Tuberculosis | Asthma |
|  | | |
| Have you had a skin test for allergies? If so, what was the result? | | |
| your response | | |
| Are you currently taking any prescription or over-the-counter medicines? Which ones? | | |
| your response | | |
| Provide the dates of your immunizations or type “never” or “unknown” | | |
| tetanus: date | rabies (required for handling wild mammals): date | |
|  | | |
| Are you pregnant or planning to become pregnant in the future? your response | | |
| Do you have any diseases causing immune suppression that you would like to discuss with the Occupational Health Clinician? your response | | |
| Do you have any health or workplace concerns not covered by this questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the Occupational Health clinicians or your personal care physician? your response | | |