Student Health Center
Vanderbilt University Medical Center
Animal Allergy Questionnaire
Patient Completed Information

Patient Label or Patient Identifiers

Vanderbilt Student Health Center
Campus Mail: Zerfoss Building, Station 17, (8710)
Secure fax: (615) 343-0047

Today's Date: _____/_____/_____

Name: (Last, First) _____

Department: _____ Emp ID: _____

Date of Birth: _____ Phone number (work): _____

☐ Veterinarian ☐ Animal Care Tech ☐ Graduate Student Worker ☐ Undergraduate Student Worker
☐ Principal Investigator ☐ Other Research Staff ☐ DAC Office Administration

List all animal species you worked with during the past year. If you are just starting to work with animals, list the species you plant to work with (Check all that apply!)
☐ Rodents ☐ Macaques ☐ Other Primates ☐ Bats ☐ Dogs ☐ Sheep ☐ Other _____

NOTE: If you do not work directly with live animals, but DO enter animal housing facilities or work with animal tissue, please list the type of animal: _____

If you do not currently work with animals, did you work with animals/animal tissues in the past? ☐ Yes ☐ No
(We will verify with IACUC that you no longer need to complete as survey. In the mean time, please sign a **declination** form)

Hours per week exposed to lab animals: _____

Animals you have at home: _____

Are you allergic to any drugs, foods, animals, pollens, molds, or other environmental agents? ☐ Yes ☐ No

If yes, Please list you allergies: _____

How often do you experience any of the following symptoms ***when you are around animals at work***?

	Never	Once a week or less	More than once a week
Wheezing	(0)	(2)	(2)
Shortness of breath	(0)	(2)	(2)
Chest tightness	(0)	(2)	(2)
Skin rash	(0)	(2)	(2)
Sneezing	(0)	(0)	(2)
Itchy eyes	(0)	(0)	(2)
Watery eyes	(0)	(0)	(2)
Runny Nose	(0)	(0)	(2)
Coughing	(0)	(0)	(2)

Do you wear an N-95 respirator (TB mask) to control your allergy symptoms? ☐ Yes ☐ No
☐ Yes I have read the required information "Allergies to Animals" on the VOHC website at http://occupationalhealth.vanderbitl.edu/article/animal-allergies
☐ I verify that the above information is accurate to the best of my knowledge.

Patient/Legal Representative Print Name: _____

Patient/Legal Representative Signature: _____

Relation: _____ Date: _____ Time: _____

For SHC use only: Highest Score _____

Print Name: _____ Title: _____

Signature: _____ Date: _____ Time: _____

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