UCSD Environment Health and Safety
Occupational Health Program
Biosafety Level 3/2+ Medical Surveillance

PART 3: MEDICAL HISTORY

Purpose: This information will be used by the Occupational Health Professional (OHP) to make an accurate assessment of your ability to safely work in the Biosafety Level 3/2+ (BSL3/2+) laboratory. The OHP will evaluate the information on this form and document for you and your supervisor any protective measures or work restrictions to be followed. The BSL3/2+ Medical Surveillance is to be completed prior to starting work in a BSL3/2+ lab and periodically to assess ongoing risks and fitness for duty. Additional evaluation may be required at the UCSD Center for Occupational and Environmental Medicine depending upon your questionnaire responses.

Your answers are confidential and need not be shown to your PI/Supervisor.

Instructions: Complete all questions. Print clearly. To protect your privacy, please put this form (Part 3) with Part 2 in a sealed envelope, and then place into a larger mailing envelope with Part 1. Receipt of all three forms is required to get medical clearance to work in the BSL3/2+ lab. Mail all three forms to: Occupational Health Nurse, Mail Code 0091, or send to *confidential* fax in a *secured* location at 858**-534-7561**.

This information is confidential and does not need to be shown to your PI/supervisor.

Name: ________________________________ UCID#: ____________________
(Please Print)
Email address: ____________________________ Phone #: ____________________

1. Do you have any of the following medical conditions or diseases?

Yes	No		Yes	No	
☐	☐	Shortness of breath, difficulty breathing	☐	☐	Tuberculosis
☐	☐	Chronic respiratory condition, asthma	☐	☐	Kidney or liver disease
☐	☐	Persistent cough (for > 3 weeks)	☐	☐	Diabetes
☐	☐	Bringing up sputum every day (for >3 weeks)	☐	☐	Chronic infectious disease
☐	☐	Coughing up blood	☐	☐	Skin conditions (e.g., eczema, psoriasis, dermatitis)
☐	☐	Unexplained weight loss (8 lbs or more)	☐	☐	Dizziness, fainting spells, seizures, epilepsy
☐	☐	Unexplained fever	☐	☐	Valvular heart disease
☐	☐	Night sweats	☐	☐	Heart disease or condition
☐	☐	Fatigue or run down feeling (for > 3 weeks)	☐	☐	History of spleen problems or absence of spleen
☐	☐	Chest pain	☐	☐	Pregnant or planning to become pregnant
☐	☐	Immune system deficiencies or other limitations to your ability to fight off disease or infection (for example: cancer, lupus, organ transplant, HIV infection)			
☐	☐	Current medication or treatment that may suppress your immune system (for example: steroids, prednisone, chemotherapy, radiation therapy) If yes, provide list:			
☐	☐	Any other health conditions that you think could be adversely affected by working in a BSL3/2+ facility?			
☐	☐	Any known allergies (chemicals, latex, animals, food, environmental)?			

Explain all "yes" responses (print clearly): ____

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Biosafety Level 3/2+ Medical Questionnaire

Part 3 Medical History – Continued

Name: ____

2. Do you currently wear a mask or respirator? ☐ **Yes** ☐ **No** **If yes, answer the following questions:**

Type of mask/respirator: ☐	Have you been fit tested? ☐ Yes ☐ No
For what reason/hazard are you using mask/respirator:	
Is respirator use <u>required</u> in your work area? ☐ Yes ☐ No If yes, complete the respirator medical questionnaire and registration form if you have not done so in the past year, and send with this Part 3 form. (Respirator medical forms: http://blink.ucsd.edu/safety/occupational/PPE/respiratory/respirator.html#2.-Apply-for-medical-approval.	

3. Immunization History

Yes	No		
☐	☐	Have you received Hepatitis B vaccination? Have you had your titer checked?	If yes, list dates: If yes, list date:
☐	☐	Have you ever had a positive TB screening?	If yes, list date:
☐	☐	Have you ever received BCG vaccination?	If yes, list date:
☐	☐	Have you had a TB skin test in the past 2 years? If yes, list date(s): Result: ___Neg ___Pos	
☐	☐	Have you had a Quantiferon TB screening? If yes, list date(s): Result: ___Neg ___Pos	

<u>NOTE</u>: attach a copy of your immunization, TB screening or titer records

Authorization to Disclose Protected Health Information: I authorize UCSD EH&S to disclose to UCSD Center for Occupational & Environmental Medicine the specific information described above including my Hepatitis B vaccination declination.

______________________________ ____________ ____________ AM/PM
PARTICIPANT SIGNATURE DATE TIME

<u>COEM Use Only</u>

______________________________ ________ ____________ ____________ AM/PM
REVIEWING CLINICIAN SIGNATURE PID# DATE TIME

If you are a UCSD employee or affiliate with questions, contact Bobbi Sawtelle, Occupational Health Nurse, (858) 534-8225 or bsawtelle@ucsd.edu