

Health Assessment Form – *Brucella* exposure

Last exposure date: ____/____/____ + 28 days = ____/____/____

Please complete the health assessment form below for each day of contact with *Brucella abortus* until **28** days after your last exposure. If you develop fever within **28** days of your last exposure, contact your occupational health personnel immediately.

Last name: _____ First name: _____ Date of birth: ____/____/____

Laboratory: _____ Work Phone: _____ Home phone: _____

	Date ____/____/____ Circle one	Date ____/____/____ Circle one	Date ____/____/____ Circle one	Date ____/____/____ Circle one	Date ____/____/____ Circle one
Fever	Yes No Temp: _____°F	Yes No Temp: _____°F	Yes No Temp: _____°F	Yes No Temp: _____°F	Yes No Temp: _____°F
Chills	Yes No	Yes No	Yes No	Yes No	Yes No
Malaise*	Yes No	Yes No	Yes No	Yes No	Yes No
Headache	Yes No	Yes No	Yes No	Yes No	Yes No
Body aches	Yes No	Yes No	Yes No	Yes No	Yes No
Sweats	Yes No	Yes No	Yes No	Yes No	Yes No
Joint Pain	Yes No	Yes No	Yes No	Yes No	Yes No
Low Back Pain	Yes No	Yes No	Yes No	Yes No	Yes No
Swollen Lymph Nodes	Yes No	Yes No	Yes No	Yes No	Yes No
Fatigue	Yes No	Yes No	Yes No	Yes No	Yes No
Anorexia**	Yes No	Yes No	Yes No	Yes No	Yes No
Other _____	Yes No	Yes No	Yes No	Yes No	Yes No
Other _____	Yes No	Yes No	Yes No	Yes No	Yes No
Other _____	Yes No	Yes No	Yes No	Yes No	Yes No

*"Malaise": general feeling of being unwell, tired, fatigued, low appetite or lack of energy

** loss of appetite

Use additional pages as needed