MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
LOCAL FORM TITLE *(Optional)*	

To enable the medical staff to protect you from an adverse reaction to latex, please answer the following questions. Your information will be kept confidential under the Privacy Act.

1. What is your occupation and place of work? _____

   How long have you worked in this setting? _____months _____years

2. Does your occupation involve contact with products containing latex? Yes ☐ No ☐ Unsure ☐

   If yes, what are those products? _____

3. Have you ever worked in a healthcare setting? Yes ☐ No ☐

   Do you work: Full time ____hour per week, ____hour per shift Part time ____hour per week, ____hour per shift

4. Have you ever had a reaction to latex? Yes ☐ No ☐ If yes, do symptoms subside away from work? Yes ☐ No ☐

   If you wear gloves at work, are they: N/A ☐ Latex with powder ☐ Powder-free latex ☐ Vinyl ☐ Other ☐

5. Have you ever been diagnosed with an allergy to a latex product? Yes ☐ No ☐ If yes, what specific item?

   _____

6. Have you had a reaction to the following latex-containing items?

Balloons	Yes ☐	No ☐	Rubber Gloves	Yes ☐	No ☐
Diaphragms	Yes ☐	No ☐	Condoms	Yes ☐	No ☐
Hot water bottles	Yes ☐	No ☐	Erasers	Yes ☐	No ☐
Rubber bands	Yes ☐	No ☐	Face masks	Yes ☐	No ☐
Rubber balls	Yes ☐	No ☐	Foam pillows	Yes ☐	No ☐
Baby bottles	Yes ☐	No ☐	Elastic waist bands	Yes ☐	No ☐
Bottle nipples	Yes ☐	No ☐	Pacifiers	Yes ☐	No ☐
Ostomy bags	Yes ☐	No ☐	Bras, suspenders	Yes ☐	No ☐
Orthodontics	Yes ☐	No ☐	Athletic shoes	Yes ☐	No ☐
Band-aids	Yes ☐	No ☐	Poinsettia plants	Yes ☐	No ☐
Elastic tape	Yes ☐	No ☐	Other_____	Yes ☐	No ☐

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

7. After handling latex products, have you ever experienced:

Skin redness	Yes ☐	No ☐	Breathing problems	Yes ☐	No ☐
Swelling	Yes ☐	No ☐	Chapped hands	Yes ☐	No ☐
Hives	Yes ☐	No ☐	Runny nose	Yes ☐	No ☐
Itching	Yes ☐	No ☐	Other_____	Yes ☐	No ☐

8. Have you had significant problems with:

Asthma	Yes ☐	No ☐	Contact dermatitis	Yes ☐	No ☐
Eczema	Yes ☐	No ☐	Autoimmune illness	Yes ☐	No ☐
Hay fever	Yes ☐	No ☐	Conjunctivitis	Yes ☐	No ☐
Rhinitis	Yes ☐	No ☐	Other_____	Yes ☐	No ☐

9. Do you have any food allergies? Yes ☐ No ☐

	Recent	> 1 year ago		Recent	> 1 year
Bananas	☐	☐	Kiwi	☐	☐
Avacados	☐	☐	Chestnuts	☐	☐
Potatoes	☐	☐	Peaches	☐	☐
Tomatoes	☐	☐	Papaya	☐	☐
Milk	☐	☐	Passion fruit	☐	☐

10. Have you had any reactions during or after dental work? Yes ☐ No ☐

If so, please describe:_____

11. Have you had any reaction during a Medical or GYN exam? Yes ☐ No ☐

If so, please describe:_____

12. Have you ever had surgery? Yes ☐ No ☐ If so, how many surgeries?_____

13. Have you had an allergic reaction during anesthesia? Yes ☐ No ☐

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