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
IMPLEMENTATION OF A LATEX-SAFE HOSPITAL ENVIRONMENT NHPINST 6200.12C	07 May 2012
LOCAL FORM TITLE *(Optional)* LATEX ALLERGY SCREENING QUESTIONNAIRE	

Name: _____ ☐ Male ☐ Female

Department: _____

Position: _____ Duty-Telephone: _____

(NOTE: Allergic symptoms may include sneezing, runny nose, hand rash, wheezing, eczema, hives, hypotension, anaphylaxis, etc)

1. Do you have regular contact with latex gloves or other rubber products? ☐ Yes ☐ No
2. Do you have any allergic symptoms after eating any of the following?

Avocado	☐ Yes	☐ No	Banana	☐ Yes	☐ No	Potato	☐ Yes	☐ No
Tomato	☐ Yes	☐ No	Chestnut	☐ Yes	☐ No	Kiwi	☐ Yes	☐ No

3. Are you allergic to any other plants? ☐ Yes ☐ No
   If YES, specify: _____
4. Have you ever had any side effects or allergic symptoms associated with exposure to latex gloves or any other product containing rubber or latex (e.g., balloons, condoms)? ☐ Yes ☐ No
   If YES, specify: _____
5. Have you ever had frequent dental procedures or any medical condition or problem that resulted in multiple operations or chronic medical instrumentation, such as urinary catheterization? ☐ Yes ☐ No
6. Have you ever experienced hay fever, eczema, or contact dermatitis as a result of exposure to latex or latex containing products? ☐ Yes ☐ No
   If YES, specify: _____
7. Have you ever experienced anaphylaxis, hives, or symptoms of asthma as a result of exposure to latex or latex containing products? ☐ Yes ☐ No
   If YES, specify: _____
8. Have you ever experienced any allergic reaction to anything not included in any of the questions above? ☐ Yes ☐ No
   If YES, specify cause if known: _____

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	