

Long Beach Memorial Medical Center Surgical Services Screening Questionnaire for Latex Sensitivity

1. Have you been told by a doctor that you are allergic to latex? Yes No

2. Have you had a reaction to any of the following items within one hour of exposure? Reactions include itching, redness, swelling, hives, runny nose, congestion, wheezing, or chest tightness.

Adhesive tape	<input type="checkbox"/> Yes <input type="checkbox"/> No	Elastic underwear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Balloon	<input type="checkbox"/> Yes <input type="checkbox"/> No	Face pillow	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bandage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Garden hose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brassiere	<input type="checkbox"/> Yes <input type="checkbox"/> No	IV tubing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Condom	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dish gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental cofferdam	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacifier	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental mask	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rubber ball	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bite block	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rubber cement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Face mask	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rubber gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No
Golf grip	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tennis grip	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ostomy bag	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shoes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rubber band	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Other items that you have reacted to that you think contain latex: _____

3. a) How many surgeries have you had in the past? _____
 b) Have you had any bad reactions? Yes No

4. Do you suffer from:

Seasonal hay fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Do you have on-the-job exposure to latex? Yes No

6. Were you born with problems involving your spinal cord? Yes No

7. Do you catheterize yourself to urinate? Yes No

8. Do you have any food allergies? Yes No

a) If yes, are you allergic to any of the following?

Kiwi fruit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Avocados	<input type="checkbox"/> Yes <input type="checkbox"/> No	Papaya	<input type="checkbox"/> Yes <input type="checkbox"/> No
Guacamole	<input type="checkbox"/> Yes <input type="checkbox"/> No	Banana	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chestnuts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Passion fruit	<input type="checkbox"/> Yes <input type="checkbox"/> No

b) What symptoms do you experience when in contact with these foods?

9. Are you allergic to latex or products containing rubber? Yes No

If yes, are the symptoms

A rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hives?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Itching?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watery eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest tightness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anaphylaxis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. Do you have allergic symptoms while:

Blowing up balloons?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During dental examinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
On contact with diaphragms/condoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During vaginal or rectal exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
While wearing rubber gloves?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Reviewed by: _____

Addressograph