**MEDICAL RECORD - OCCUPATIONAL HEALTH SURVEILLANCE FOR LATEX SENSITIVITY**

For use of this form see MEDCOM Reg 40-44

OTSG APPROVED (Date)

| DEPARTMENT | OCCUPATION | NUMBER OF YEARS IN OCCUPATION | WORK PHONE |
|---|---|---|---|
| | | | |

1. Has a doctor ever told you that you have an allergy to any latex products? ☐ Yes ☐ No

If YES, to what specifically did the doctor say you were allergic? _____

2. Do you have a history of :
☐ Contact Dermatitis ☐ Rhinitis or Conjuctivitis ☐ Eczema
☐ Spina Bifida ☐ Hay Fever ☐ Asthma
☐ Auto Immune Disease (i.e., thyroid disease, diabetes, lupus)

3. Please check product(s) to which you have a noted reaction:

| | | | |
|---|---|---|---|
| ☐ Surgical Gloves | ☐ Enema Cuffs | ☐ Rubber Bands/Binders | ☐ Ostomy Bags |
| ☐ Catheters | ☐ Dental Darns | ☐ Anesthetic Mask | ☐ Intestinal Tubes |
| ☐ Buretrols | ☐ Condoms | ☐ Rebreather Bags | ☐ Ostomy Tubes |
| ☐ Diaphragm | ☐ Elastic Adhesives (bandaids) | ☐ Power in Latex Gloves | ☐ Other _____ |
| ☐ Intubation Tubes | ☐ Vial with Latex Tops | ☐ Elastic Threads | |
| ☐ Blood Pressure Cuffs | ☐ Tubing (Latex Ports) | ☐ Ballons | |

4. Type of reaction noted:

| | | | |
|---|---|---|---|
| ☐ Sneezing | ☐ Itchy Skin | ☐ Chapped/Cracking Hands | ☐ Stuffy Nose |
| ☐ Low Blood Pressure | ☐ Itchy Throat | ☐ Shortness of Breath | ☐ Runny Nose |
| ☐ Wheezing | ☐ Itchy Ears | ☐ Lost of Consciousness | ☐ Watery Eyes |
| ☐ Tight Chest | ☐ Itchy Eyes | ☐ Rash | |
| ☐ Other _____ | | | |

5. Do you have any food allergies? ☐ Yes ☐ No If YES, are you allergic to any of the following?

| | | | |
|---|---|---|---|
| ☐ Kiwi | ☐ Banana | ☐ Chestnut | ☐ Avocado |
| ☐ Passion Fruit | ☐ Tomato | ☐ Papaya | ☐ Peaches |
| ☐ Potato | ☐ Milk | ☐ Grape | ☐ Other _____ |

6. Have you had any previous surgery? ☐ Yes ☐ No If YES, how many? _____

What types? _____

7. Have you ever had any allergic or unusual symptoms following a dental, gynecological, or rectal procedures? ☐ Yes ☐ No

If YES, explain: _____

8. Have you ever had hives, asthma, swelling and tightness in the throat or other unusual reaction to latex products or devices? ☐ Yes ☐ No

If YES, explain: _____

OCCUPATIONAL HEALTH NURSE COMMENTS:

☐ List of products containing latex issued ☐ Educational material reviewed and issued
☐ Aware of available powderless latex gloves and non-latex supplies at CMS

| PREPARED BY (Signature and Title) | DEPARTMENT/SERVICE/CLINIC | DATE |
|---|---|---|
| | | |

PATIENT IDENTIFICATION

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES _____
☐ TREATMENT _____