



EMPLOYEE HEALTH SERVICES

57 Bee Street – MSC 213
Charleston, SC 29425-2130
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LATEX ALLERGY QUESTIONNAIRE

Last Name _____ First _____ MI _____
Birth date ____ / ____ / ____ MUSC Employee ID _____
Dept. _____ Position _____ Work # _____ Home # _____

1. Please answer the following questions:

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to latex? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear latex gloves? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your fellow healthcare workers wear latex gloves? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer from skin rashes on your hands? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had many surgeries? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have hay fever or other common allergies? |

2. If you have ever worn latex gloves:

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a rash, itching, or cracking of your hands? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have these symptoms recently changed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been using different types of rubber gloves? |
| <input type="checkbox"/> | <input type="checkbox"/> | If you have tried non-latex gloves, did your problem persist? |

3. When you are wearing or around others that are wearing latex gloves, have you noted any:

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy, red eyes, fits of sneezing, runny or stuffy nose? |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath, wheezing, or chest tightness? |

4. Have you had:

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching, swelling, or other symptoms after a dental, rectal, or pelvic exam? |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling or difficulty breathing after blowing up a balloon? |
| <input type="checkbox"/> | <input type="checkbox"/> | An allergic reaction, which required treatment from a doctor? |

5. If you have answered YES to any of the above questions, please explain: _____

6. Circle foods that cause hives, itching of lips or throat, or other severe symptoms when you eat or handle them.

Avocado Banana Tomatoes Carrots Hazelnuts Melon Kiwi Cherries Peaches Celery Plums Papaya

EHS PERSONNEL PLEASE COMPLETE THIS SECTION

- | | | | | |
|-------------------|------------------------------|----------------------------------|----------------------------------|------------------------------------|
| EVALUATION | <input type="checkbox"/> YES | <input type="checkbox"/> SUSPECT | <input type="checkbox"/> NO | Possible latex allergy? |
| | <input type="checkbox"/> YES | | <input type="checkbox"/> NO | Is IgE RAST lab testing indicated? |
| | <input type="checkbox"/> EHS | | <input type="checkbox"/> PRIVATE | Blood Drawn to be drawn by? |

EHS Signature: _____ **Date:** _____