

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

**OCCUPATIONAL HEALTH LATEX & RUBBER HYPERSENSITIVITY
SCREENING QUESTIONNAIRE**

OTSG APPROVED (Date)

PART I - PATIENT QUESTIONNAIRE

1. Name (Last, First, MI)		2. Grade	3. Social security number	4. Age	5. MOS/Specialty/Series
6. Work location		7. Type of job you perform <input type="checkbox"/> Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse <input type="checkbox"/> Medic <input type="checkbox"/> Laboratory worker <input type="checkbox"/> Housekeeping <input type="checkbox"/> Other:			8. Duty phone
9. How many years have you worked in health care facilities?		10. Have you ever had an adverse reaction to a rubber or other latex-containing product at home or at work? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you answered "No" to this question, skip items 11 and 12.)			
11. Indicate the symptoms you have experienced with rubber or other latex-containing product. (Select all that apply.)					
a. Skin: <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Redness <input type="checkbox"/> Irritation					
b. Mouth, Eyes and Nose: <input type="checkbox"/> Itchy <input type="checkbox"/> Tears <input type="checkbox"/> Watery <input type="checkbox"/> Redness					
c. Lungs: <input type="checkbox"/> Asthma <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest discomfort					
d. Heart: <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Fast pulse <input type="checkbox"/> Lightheadedness					
e. Stomach: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal pain					
12. Have you been previously evaluated for latex allergy with a blood test or skin test? <input type="checkbox"/> Yes <input type="checkbox"/> No					
13. How frequently is (or has been) your contact with latex materials? <input type="checkbox"/> Rare <input type="checkbox"/> Weekly <input type="checkbox"/> Daily					
14. Do you have a history of seasonal allergic rhinitis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
15. Do you have a history of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No					
16. Do you have a history of year-round allergic rhinitis (constant runny nose)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
17. Do you have a history (current or past) of eczema, atopic dermatitis or allergic skin rashes? <input type="checkbox"/> Yes <input type="checkbox"/> No					
18. Do you have any food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," please specify.) <input type="checkbox"/> Bananas <input type="checkbox"/> Kiwi <input type="checkbox"/> Avacado <input type="checkbox"/> Chestnuts <input type="checkbox"/> Papaya <input type="checkbox"/> Other:					
19. Do you have any chronic medical problems where repeated exposure to latex-containing products occur? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," please describe.)					

PART II - TO BE COMPLETED BY CLINICAL STAFF

20. Does the patient have a previous documented latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Has the patient been referred to the allergy clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Remarks	

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

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