

MCLAREN BAY REGION  
Latex Allergy Screening

1. Have you ever been told by a doctor that you have an allergy to any latex product? .....Y      N
2. Have you ever experienced allergic symptoms after contact with latex or rubber.....Y      N  
If yes, do the symptoms include any of the following? (Circle ALL that apply)

Hives	Itching	Swelling	Wheezing
Sneezing	Skin rash	Palpitations	Difficulty breathing
Watery eyes	Collapse		

3. Have you ever had allergic reactions while: (Check ALL that apply)

- ( ) Blowing up balloons
- ( ) During dental, vaginal, or rectal exams
- ( ) On contact with diaphragms/condoms
- ( ) While wearing rubber gloves
- ( ) While wearing spandex clothing or from elastic bands on clothing

4. Do you have a medical history of frequent surgeries or extensive dental procedures? .....Y      N

5. Have you ever had a strong allergic reaction(anaphylactic) or other unexplained reaction during or following a medical procedure? .....Y      N

6. Does your occupation require you to have frequent contact with latex? .....Y      N

7. Do you have any food allergies? YES\_\_\_\_\_ NO\_\_\_\_\_
- If yes, are you allergic to any of the following? (please circle)

Kiwi fruit	Avocados	Carrot	Apple
Hazelnut	Peach	Banana	Potatoes
Melons	Celery	Papaya	Passion fruit
Chestnuts	Tomatoes		

8. Do you have a history of:

Hay fever.....	Y	N
Eczema.....	Y	N
Autoimmune disease.....	Y	N
Chronic asthma.....	Y	N
Contact dermatitis.....	Y	N
Spinal cord abnormality.....	Y	N

\_\_\_\_\_

Employee Signature

\_\_\_\_\_

Date

Comments:\_\_\_\_\_

\_\_\_\_\_

Signature of Physician/Nurse

\_\_\_\_\_

Date