

**Grand View University Department of Nursing
Latex Allergy Questionnaire**

Have you ever suffered from:	Yes	No	If yes, please explain
Allergic Rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unexplained Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reactions to Band-Aids and Tape	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever reacted after handling:			
Balloons	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubber Products	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clothing with elastic or stretchy fabrics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elastic Bandages	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poinsettias	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any of the following symptoms after dental work?			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue/drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Facial swelling/redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever reacted after eating:			
Bananas	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avacados	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tropical fruit/kiwi/papaya	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chestnuts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shellfish	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear latex gloves?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do your fellow healthcare workers wear gloves?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you suffer from skin rashes on your hands when you wear latex gloves?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If you have tried non latex gloves, did your problem persist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had several surgical procedures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a history of a spinal cord injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Signature _____ Date _____