



North Shore-Long Island Jewish Health System

Screening for Allergies/ Sensitivities to Latex Products

First Name: _____ Last Name: _____ DOB : ____/____/____

Dept/Div: _____ Title/Position _____

Today's Date: ____/____/____ Work Phone Number: (____) _____ - _____ ext. _____

1. Do you have a history of Latex Allergy reactions?Yes No

If yes, please explain: _____

2. Are you allergic or sensitive to foods containingYes No
bananas, avocados or chestnuts?

If yes, please explain: _____

3. Do you develop itching, wheezing or a rash from the use of:Yes No
rubber gloves or rubber bands or blowing up balloons?

If yes, please explain: _____

4. Have you ever tested positive for a latex skin or blood test?.....Yes No

If yes, please explain: _____

5. Have you ever had a prior unexplained allergic or anaphylactic reactionYes No
during a medical procedure (also known as a system reaction)?

If yes, please explain: _____
