



ANNUAL LATEX ALLERGY FOLLOW-UP

The completed form should be returned to and will be reviewed by:

OH&S Employee Health
Attention: Occupational Health Nurse Coordinator
Address: CH19, Suite 445
Phone: 934-2487
Fax: 934-7487

YOUR RESPONSES ARE STRICTLY CONFIDENTIAL

Please complete <u>ALL</u> of the following information:				DATE: _____	
Check all that apply: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Male <input type="checkbox"/> Female Are you employed by UAB? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Last Name		First Name		MI	
Job Title		Work Address		Blazer ID	
Birth Date		Employee #		Email	
Work Phone		Alt. Phone			
Dept.		Supervisor Name		PI	
Specify best method of contact (if by phone or pager, provide number):					
In the space below, please provide a brief job description (use back of form if more space is required):					

- Status:** (Check all that apply)
- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Faculty | <input type="checkbox"/> Staff | <input type="checkbox"/> Research Technician/Associate |
| <input type="checkbox"/> Student | <input type="checkbox"/> Veterinarian | <input type="checkbox"/> Microbiologist |
| <input type="checkbox"/> Post Doc | <input type="checkbox"/> Pathologist | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Visiting Scientist | <input type="checkbox"/> Biologist | <input type="checkbox"/> Other
(specify) _____ |

- Do you have a history of (check all that apply):
- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Atopy | <input type="checkbox"/> Autoimmune disorders |
| <input type="checkbox"/> Exzema | <input type="checkbox"/> Childhood surgery |
| <input type="checkbox"/> Congenital abnormalities (such as Spina Bifida) | |

Concerning your Latex allergy, please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Local rash within minutes of latex exposure | <input type="checkbox"/> Itching with bumps/hives |
| <input type="checkbox"/> Local rash hours to days after exposure | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Occurs only with powdered gloves | <input type="checkbox"/> Shortness of breath (SOB) |
| <input type="checkbox"/> Rash located on hands or wrists | <input type="checkbox"/> Chest tightness |
| <input type="checkbox"/> Rash occurs on other areas of skin | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Worsen asthma | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Itching eyes |

Please check any other symptoms or complaints that latex exposure causes.

Skin

- Rash
- Hives
- Eczema
- Swelling
- Itching
- Redness

Nasal/Sinus

- Runny or stuffy nose
- Sneezing
- Itchy Nose
- Poor sense of smell
- Post nasal drainage

Throat

- Soreness
- Hoarseness
- Bad breath
- Swelling

Eye

- Itching
- Watering
- Burning
- Redness
- Puffiness
- Dark circles
- Matting in morning

Chest

- Wheezing
- Coughing
- Tightness
- Shortness of breath
- Frequent bronchitis

Do any of the following items cause your rash, irritation or any of the above symptoms (even if mild)?

Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Balloons | <input type="checkbox"/> Rubber balls |
| <input type="checkbox"/> Face mask | <input type="checkbox"/> Foam pillows |
| <input type="checkbox"/> Elastic in clothing | <input type="checkbox"/> Any other rubber items (please list): |
| <input type="checkbox"/> Rubber bands | |

Please check what you have done to decrease your symptoms:

- | | |
|---|--|
| <input type="checkbox"/> use of non-powdered gloves | <input type="checkbox"/> use of Nitrile gloves |
| <input type="checkbox"/> use of non-latex gloves | <input type="checkbox"/> changed jobs |

Medications: (if so, please list) _____

Assurances:

I certify that information provided is true and complete to the best of my knowledge. I understand that any intentional false statement or omission of facts may be grounds for dismissal. I have read the information in this form. I am aware that some health conditions may increase my risk to injury or illness when working with research animals. I understand that I should make my physician aware of these conditions and my duties.

Signature

Date