

LATEX ALLERGY QUESTIONNAIRE

(5).....1. Have you ever had an anaphylactic reaction to latex devices or products?..... Yes  No

(1).....2. Do you have any of the following conditions:

Spina bifida, myeloma, myelodysplasia?..... Yes  No

(\*).....3. Have you had a reaction to the following personal sources of latex?..... Yes  No

If Yes, check all that apply:

- Balloons, Rubber Gloves, Belts, Bras, Suspenders, Latex Birth Control Devices, Dental Cofferdams, Cuffs, Elastic Waistbands, Erasers, Face Masks, Rubber Grips, Hot Water Bottles, Rubber Bands, Balls, Ostomy Bags, Foam Pillows, Baby Bottles, Nipples, Shoeware, Pacifiers, Teething rings, Elastic Bandages

(4).....If you have checked any of the above in # 3 have you experienced any of the following reactions?..... Yes  No

- Wheezing / Shortness of Breath, Immediately on Contact to the product (Urticaria, Hives), Chest Tightness

(\*)....."YES" answers to the following indicates potential for latex sensitivity:

- Runny Nose / Congestion, Swelling, Itching (eg. hands, eyes), Chapping or "Cracking" of the Hands

(\*).....4. Do you have any allergies to the following foods?..... Yes  No

- AVOCADOS, POTATOES, KIWIS, PAPAYA, BANANAS, CHESTNUTS, PEACHES, TOMATOES

(3).....If you have checked any of the above in # 4 have you experienced any of the following reactions?..... Yes  No

- Wheezing / Shortness of Breath, Immediately on Contact to the food (Urticaria, Hives), Chest Tightness

(\*)....."YES" answers to the following indicates potential for latex sensitivity:

- Runny Nose / Congestion, Swelling, Itching (eg. hands, eyes), Chapping or "Cracking" of the Hands

(1).....5. As an infant / child did you have multiple surgeries?..... Yes  No

(1).....6a. Are you a health care worker and have repeated exposure to products containing LATEX?..... Yes  No

If yes, which products do you have repeated exposure to?.....

(1).....6b. Does your job involve working in a factory where rubber or latex products are manufactured?..... Yes  No
If yes, which products do you manufacture?.....

MAXIMUM SCORE POSSIBLE: 16—4 or BELOW complete # 1A & 1B

1. TOTAL SCORE \_\_\_\_\_

If 5 or ABOVE, complete # 2 & 3 and INITIATE LATEX PRECAUTIONS
If 4 or BELOW and "YES" ANSWERS are marked for SENSITIVITY – questions 3 & 4

1a. PHYSICIAN(S) NOTIFIED  Yes (name of MD / Time)  No

1b. Does Physician want to initiate LATEX PRECAUTIONS?  Yes  No

If 5 or above continue the following questions:

2. Identification of patient and room:

- LATEX added to allergy computer screen?  Yes Patient banded with "LATEX PRECAUTIONS armband.  No
LATEX PRECAUTIONS sticker  Yes - on door  Yes - on bed  Yes - on wall  Yes - on chart
KARDEX marked with "LATEX PRECAUTIONS  Yes

3. Physician(s) Notified: Patient placed on "LATEX PRECAUTIONS" (name of MD / Time) \_\_\_\_\_

RN / LVN / RT / PT / OT / MA

Date

Name:

GRAYBILL MEDICAL GROUP
225 E Second Ave
Escondido, Ca 92025



# TB CONSENT FORM

## TB QUESTIONS TO ASK PATIENTS


### TB QUESTIONS TO ASK PATIENTS

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Name: \_\_\_\_\_

	Yes	No
1. Have you ever had TB (Tuberculosis)?	_____	_____
2. Have you been living with anyone in the past 2 years who has been diagnosed with TB?	_____	_____
3. Have you had a persistent cough and fever for more than 2 weeks?	_____	_____
4. Have you had a persistent cough and night sweats for more than 2 weeks?	_____	_____
5. Have you had a persistent cough and loss of appetite for more than 2 weeks?	_____	_____
6. Have you been coughing up or spitting up bloody sputum (saliva)?	_____	_____



**Graybill Medical  
Group, Inc.**

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PAST HISTORY / SELF:**

<b>Medical History Year /Onset</b>	<b>Disease</b>	<b>Comments</b>
<b>Surgical History Date of Operation</b>	<b>Operation</b>	<b>Comments</b>
<b>Diagnostic History Date of test</b>	<b>Test- example: CT Scan, MRI, Ultrasound, X-rays or Angiograms</b>	<b>Results</b>

See Reverse Side

**Social History:**

Date of Birth \_\_\_\_\_

Residence \_\_\_\_\_

Birthplace \_\_\_\_\_

Religion \_\_\_\_\_

Education \_\_\_\_\_ Military Service \_\_\_\_\_

Occupation \_\_\_\_\_

Recent Foreign Travel \_\_\_\_\_

Marital Status \_\_\_\_ Years Married \_\_\_\_\_ Anniversary \_\_\_\_\_

Spousal Health \_\_\_\_\_

Sexual preference \_\_\_\_\_ Birth control \_\_\_\_\_

**Tobacco**  Yes  No  Former ( Year Quit \_\_\_\_\_ ) Packs per day \_\_\_\_\_ Years smoked \_\_\_\_\_

**Alcohol**  Yes  No Drinks per day \_\_\_\_\_ Year quit \_\_\_\_\_

**Caffeine**  Yes  No Amount daily \_\_\_\_\_

**Illicit Drugs**  Yes  No Former  Year Quit \_\_\_\_\_

Exercise \_\_\_\_\_

Recreation \_\_\_\_\_

**Answer yes or no to the following:**

**Safety** Firearms at home \_\_\_\_\_ Seatbelt Use? \_\_\_\_\_ Sun Exposure? \_\_\_\_\_

Smoke detector in home? \_\_\_\_\_ Carbon monoxide detector in home? \_\_\_\_\_

**ADVANCE DIRECTIVES:** None \_\_ DNR(Do Not Resuscitate) \_\_ Living Will \_\_

**Allergies:** ( ) No ( ) Yes *If yes, please list: below and reaction*