CLINICAL PROFILE/ALLERGY QUESTIONNAIRE

NAME: _____ (Circle): Male Female

HEIGHT: _____ (ft.) _____ (in.) **WEIGHT:** _____ (lbs.)

For Hospital Use Only ☐ Actual ☐ Stated

ADVANCED DIRECTIVE: (Check all that apply)

- ☐ Living Will
- ☐ Health Care POA
- ☐ DNR
- ☐ None

For Hospital Use Only
- ☐ Copy on file
- ☐ Requested

ALLERGIES:

NAME	REACTION	SEVERITY (Mild, Moderate, Severe)

Effective Date	Reviewed/Revised Date	Change Description
7/14	Revised 7/14	Added Male Female