Patient Completed Allergy/Current Medication Form

Complete this Form. Mail in provided envelope or FAX to 219-8719.

Patient (Full) Name:______________________________ Date of Birth: ____/____/____ Sex: M____ F____

☎ Home ______________ Work ______________ Cell______________ Height ______________ Weight ______________

Family Doctor:______________________ Surgeon:______________________ Date of Procedure: ____/____/

Procedure:____

LIST ALL ALLERGIES (medication/foods/environmental/tape/dye/other):

To What	Describe Reactions	To What	Describe Reactions

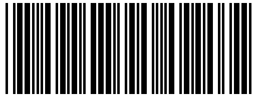
Have you ever had an allergic reaction to latex products (gloves, balloons)? No____ Yes____ Describe:______________

Have you taken Steroids for any condition in the last 6 months? No____ Yes____ What: ______________

Have you taken any prescription of non-prescription meds to lose weight? No____ Yes____ What:______________

Medication Name (example: Pepcid)	Strength on Prescription Label (example: 40mg)	How much are you taking and at what times of the day? (example: 2 tablet twice a day at 8 a.m. & 9 p.m.)	Reason for taking (example: ulcer)	Pharmacy name and phone # on prescription label
PRESCRIPTION MEDICATIONS (including daily aspirin, oxygen, inhalers, eye drops, etc.):				
NON-PRESCRIPTION MEDICATIONS (over-the-counter medications, herbal remedies, vitamin & mineral supplements):				

CHI Health St. Elizabeth, Lincoln, NE



If you have questions call (402) 219-7049.

Medication Name (example: Pepcid)	Strength on Prescription Label (example: 40mg)	How much are you taking and at what times of the day? (example: 2 tablet twice a day at 8 a.m. & 9 p.m.)	Reason for taking (example: ulcer)	Pharmacy name and phone # on prescription label
PRESCRIPTION MEDICATIONS (including daily aspirin, oxygen, inhalers, eye drops, etc.):				
NON-PRESCRIPTION MEDICATIONS (over-the-counter medications, herbal remedies, vitamin & mineral supplements):				CHI Health St. Elizabeth, Lincoln, NE