SSMHealth
Oklahoma Spine Hospital
Physician Owned

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)

	For Hospital Use Only
☐ Living Will	☐ Copy on file ☐ Requested
☐ Health Care POA	☐ Copy on file ☐ Requested
☐ DNR	☐ Copy on file ☐ Requested
☐ None	

ALLERGIES:

NAME	REACTION	SEVERITY (Mild, Moderate, Severe)