Allergy and Health Information

Last name_____ **First name**_____ **Middle** _____

Date of birth___/____/____

Allergies/Drug reactions_____

_____

Diseases/chronic health conditions: Diabetes Hypertension Cancer

Cholesterol Pregnancy/nursing Other:_____

Prescriptions from other sources (not from Hotel Pharmacy):

_____

_____

Over the counter medications/supplements you are currently taking:

Vitamins Aspirin Herbal supplements_____

Other_____

_____

_____

*Please provide additional information on the OTC products you are taking such as when you take them, name of medication/supplement(s), and how long you have been taking them.