Mountain View TLC

A Total Life Concept For Healthcare, Fitness, Nutrition, and Behavioral Health

MEDICATIONS LIST: (continue on the back of the page if needed)

What is your preferred pharmacy?

_____

1. Have you ever had an **allergic reaction** to any medications? No Yes
   If yes, please specify:

   Medication: _____ Reaction: _____
   Medication: _____ Reaction: _____
   Medication: _____ Reaction: _____

2. Please list all **prescription** medications you take, including any injections or inhalers:

	Name of Medication	Amount per Dose	Times taken per day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Do you use oxygen?
If so, when? _____ Liters/minute_____

3. Please list any **non-prescription supplements** (over-the-counter meds, vitamins, etc):

	Name of Supplement	Amount per Dose	Times taken per day
1			
2			
3			
4			
5			
6			
7			
8			