



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	_____	_____	_____