The Doctors' Weight Management Program – Medication List (Part II)

→ → → Please answer the following questions and have ready when you call us to tell us you've completed the lab work and EKG.

Name _____ **Date** _____

Medications:

Are you allergic to any medications? **Yes** **No**

If yes, which one(s)? _____

Have you previously taken any weight loss prescriptions? **Yes** **No**

If yes, when?_____

Please include all medications you are currently or have been taking for the past month (including: *over-the-counter, prescribed, herbal, vitamins and minerals*)

Medication name:	Dose:	Route:	Frequency: