OSF SAINT FRANCIS MEDICAL CENTER

OSF SURGICAL WEIGHT LOSS CENTER OF EXCELLENCE

Department Of Pharmaceutical Care Services *(Page 2 of 2)*

Over the Counter: What do you take for the following?	**1st Choice**	**2nd Choice**			
Headache?					Hardly ever
Nausea?			**How often do you miss a dose of scheduled medication? (Check one)**		1-2 times a month
Heartburn?					1-2 times a week
Constipation?					More than I can count
Diarrhea?					
Insomnia?					
Pain?					
Cough/Cold?					
Gas/Bloating?					
Other?_____					
Herbal / Nutritional Supplements	**Uses/Disease State**	**Dose & Frequency Taken**			
1)			**Please explain any medication concerns you may have:**		
2)					
3)					
4)					
5)					
6)					
7)					

**** Please complete and return this form at the Nutrition Class.***

All recommendations for changes will be faxed to your Primary Care Provider Please check with them prior to surgery to confirm any changes. Questions regarding completion of this form? Call (309)655-6805 and leave a message. Calls will be returned during regular business hours. Thank you.