EyeCare Consultants
PATIENT MEDICATION LIST

Patient Name: **DOB:** **Date:**

Current Medications that you take. Please INCLUDE all over-the-counter medications, Herbals, & Vitamins.	What is the Dosage for this medicine?	How do you take this medicine?	How often do you take this medicine?	What is this medicine prescribed for?
Example	20 mg	Once, Twice, As Needed, Etc…	AM, PM	Diabetes, Heart, Depression, Etc…

Allergies:	Reactions:	Allergies:	Reactions:

Latex Allergy? ☐ **Yes** ☐ **No** **Your Reaction to Latex if Allergic:**