Eye Surgery & Laser Center Outpatient Medication Reconciliation Form

Medication Allergies/Other Allergies and Reactions: (*Example:* **Penicillin "Rash"**) (*Example:* **Eggs: "Hives"**)
Latex Allergy: ☐ Yes ☐ NO If YES what is your reaction:_____
☐ NO HOME MEDS ☐ UNABLE TO OBTAIN MEDICATION HISTORY

MEDICATION	REACTION	MEDICATION	REACTION	MEDICATION	REACTION
1.		3.		5.	
2.		4.		6.	

PLEASE PRINT **Sx. Date: Sx. Date: Sx. Date: Sx. Date:**

Prescription Medications	Dosage	How Taken Oral, Injected, Topical	How often do you take?	Date Last Taken	Date Last Taken	Date Last Taken	Date Last Taken
Over-the –counter medication/ nutritional supplements	Dosage	How Taken Oral, Injected Topical	How often do you take?	Date Last Taken	Date Last Taken	Date Last Taken	Date Last Taken

****SEE POST OP INSTRUCTION SHEET FOR EYE DROP REGIMEN**

Above Medications: Rev'd, Noted & copy to patient: Date: _____ by: _____, _____
Nurse's Signature MD Signature

Above Medications: Rev'd, Noted & copy to patient: Date: _____ by: _____, _____
Nurse's Signature MD Signature

Above Medications: Rev'd, Noted & copy to patient: Date: _____ by: _____, _____
Nurse's Signature MD Signature

Above Medications: Rev'd, Noted & copy to patient: Date: _____ by: _____, _____
Nurse's Signature MD Signature

PATIENT LABEL