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? (Ex: 25 mg)	How do you take this medicine?	How often do you take this medicine?	What is this medicine prescribed for?

Allergies:	Reactions:	Allergies:	Reactions:

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