Today's Date:_____

Name_____

DOB_____

Pharmacy_____

Pharmacy Phone #_____

Allergies:	Reactions:

Please list the medications you are currently taking. In addition to this form please <u>bring all your medications</u> with you to your appointment.
(*OTC means anything taken that is bought over-the-counter---not a prescription)

<u>Medications</u>/*OTC/ Nutrition Supplements	Dosage (mg)	How many times a day	Indication (reason for taking)

Eye Drops	Percentage	How many times a day	Indication (reason for taking)