Patient Medication List: Please Fill Out

Patient Name: _____ DOB: _____ Today's Date: _____

Please list **Medication Allergies** and Reactions:

_____

_____

_____

_____

Ocular and Prescription Medications:

Ocular and Prescription Medications	Strength (mg, mcg, ml, etc.)	Dosage	Frequency (# of times daily)	How Taken (oral, injection, etc.)

PLEASE CONTINUE FILLING OUT ON REVERSE ☞

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Patient Medication List (Continued): Please Fill Out

Patient Name: _____ DOB: _____ Today's Date: _____

Over the Counter Medications:

Over the Counter Medication (Vitamins & Herbal Supplements)	Strength (mg, iu, ml, etc.)	Dosage	Frequency (# of times daily)	How Taken (oral, injection, etc.)

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