SOUTHERN KENTUCKY EYE CENTER

MEDICATION LIST **TODAY'S DATE ___/___/_____**

PATIENT NAME: _____ DOB: ___/___/_____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐YES OR ☐NO

IF YES PLEASE LIST:

_____

_____

PLEASE LIST ALL OCCULAR (EYE) MEDICATION YOU ARE CURRENTLY TAKING

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE THE MEDICATION	REASON FOR TAKING MEDICATION	DR PRESCRIBED MEDICATION

PLEASE LIST ALL OTHER MEDICATION THAT YOU ARE CURRENTLY TAKING PRESCRIBED BY A DOCTOR

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE THE MEDICATION	REASON FOR TAKING MEDICATION	DR PRESCRIBED MEDICATION

PLEASE LIST ALL VITIAMS AND HERBS YOU TAKE

VITAMINS OR HERBS	HOW OFTEN DO YOU TAKE

PHARMACY