EYE-Q

Patient Medication List

Please list every prescription and over-the-counter drug you are presently taking. Be sure to include the strength and dose of each medication, and how often it is taken. Bring this form with you to your surgery appointment. You can also keep this form in your wallet or purse for future reference.

Medication	Strength	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

Please list all Allergies		
1	4	7
2	5	8
3	6	9

RN Signature if completed by staff_____ Date_____