RAND EYE INSTITUTE

Medication Information

Date:		Acct #:	

LAST NAME:		FIRST NAME:		M.I.		Sal.	

Allergy Information

Please List All Allergies		

Prescribed Medication Information

Please list all Prescribed Medication that you are currently taking.

Medication Name	Strength	How Often Taken

Over the Counter, Vitamins, Herbal Supplement Information

Please list all Vitamins, Herbal Supplements, and Over the Counter that you are currently taking.

Medication Name	Strength	How Often Taken

If you need additional space, please use reverse side of form

Preferred Pharmacy Information

Pharmacy Name	Phone Number	Fax Number

Pharmacy Address	City, State, Zip

By signing below I am confirming that all the information provided is correct.

X _____ _____

Date

Allergy Information

Please List All Allergies		

Prescribed Medication Information

Please list all Prescribed Medication that you are currently taking.

Medication Name	Strength	How Often Taken

Over the Counter, Vitamins, Herbal Supplement Information

Please list all Vitamins, Herbal Supplements, and Over the Counter that you are currently taking.

Medication Name	Strength	How Often Taken