DESERT RETINA CONSULTANTS

Date: _____

MEDICATION INFORMATION SHEET

Name: _____ **DOB:** _____

Primary Doctor: _____

Pharmacy #1: _____ **City:** _____

Cross street: _____

Pharmacy #1: _____ **City:** _____

Cross street: _____

Please list all medications you are currently taking, including prescription eye drops.

EYE DROPS

Medication Name	Dose (mg/%)	How much per day?	Eye

OTHER MEDICATION

Medication Name	Dose (mg/%)	Frequency	Route

*an additional sheet is available to list medications