Patient Medication List

OPHTHALMIC SPECIALISTS OF MICHIGAN

Patient Name: _____ **DOB:** _____

Pharmacy Name: _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** _____

Please list any allergies you may have and your reaction: _____

_____

Please review the medication list below. Add any prescription drugs, over-the-counter medications, vitamins and supplements that you are currently taking.

Medication Name	Dose	Route (by mouth, eye drops, inhaler, etc.)	How often do you take this medication?	Reason you are taking this medication?