Date: _____

Eye Care & Vision Associates

Medication & Allergy Form

Name _____ **Date of Birth** _____ **Phone #** _____

Address _____ **Email** _____

***********IMPORTANT: PLEASE COMPLETE ALL PHARMACY INFORMATION IN THIS SECTION***********

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____
Street City State Zip

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING, **INCLUDING EYE MEDICATIONS**: Please include prescriptions (ex. Xalatan, Lipitor, Fosamax), over-the-counter medicines (ex. aspirin, antacids) and herbals (ex. ginseng, gingko). Also include medications taken as needed (ex. nitroglycerin).

Name of Medication (Ex. Xalatan, Lipitor, Artificial Tears, etc.)	**Dosage** (Ex. 10 mg, 250 mg, etc.)	**Type** (Ex. Tablet, Capsule, Chewable, Liquid, Injection, etc.)	**Directions** (Ex. Two times per day)

LIST ALLERGIES AND DESCRIBE REACTION:

Latex Allergy? ❑ Yes ❑ No If yes, describe reaction: