Triangle Ophthalmology

Medication Sheet

Name:_____ Date of Birth: _____ Age:_____ Chart #:_____
Instructions for this form: Please fill in your name, date of birth, and age above. Please fill in questions about drug allergies and pharmacy below. In the grid, please only fill out your medication and the dosages as best you can.

Please list all of your drug allergies and describe the reaction that you have to these medications:

_____

Current Pharmacy/Location/Phone #:_____

Date	Medication Name	Dosage/Usage	Discontinued	Tech/ MD