Gabrielle Family Vision Care Neena Gabrielle, OD, FCOVD Rachael Barker, O.D. 11411 NE 124th St., Bldg. A, Suite 118 Kirkland, WA 98034 Ph. 425-820-2143

Patient Medication / OTC Form

Name (Last, First): ______________________________

Birthday (Month/Day/Year): ______________________________

Medications: ❑ None

Type	What for

OTC / Supplements: ❑ None

Type	What for

Eye Drops: ❑ None

Type	What for

Do you have any allergies to medications? ❑ None
If yes, please list the medications you are allergic to:

Do you have any env/food/latex allergies? ❑ None
If yes, please list your allergies:

Tobacco use: Yes No
If yes, amount per day: ___________________________

Recreational Drug use: Yes No
If yes, type and amount: __________________________

Current medical (and previous visual diagnosis if seen at another clinic):
(ie. diabetes, autism, sensory processing, traumatic brain injury (concussion/sports concussion, etc.), obsessive compulsive disorder, anxiety, depression, high cholesterol, high blood pressure, etc.)(please avoid acronyms and write out diagnosis) ____

Print Name of Resp Party	Date	Dr. Initial	Date

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