Gabrielle Family Vision Care
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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		Print Name of Resp Party	Date	Dr. Initial	Date