



## Patient Medication / OTC Form

Name (Last, First): _____							
Birthday (Month/Day/Year): _____							
Medications: <input type="checkbox"/> None							
<u>Type</u>				<u>What for</u>			
OTC / Supplements: <input type="checkbox"/> None							
<u>Type</u>				<u>What for</u>			
Eye Drops: <input type="checkbox"/> None							
<u>Type</u>				<u>What for</u>			
Do you have any allergies to medications? <input type="checkbox"/> None				Do you have any env/food/latex allergies? <input type="checkbox"/> None			
If yes, please list the medications you are allergic to:				If yes, please list your allergies:			
Tobacco use:      Yes    No				Recreational Drug use:      Yes    No			
If yes, amount per day: _____				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