

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
								
								
								