NAME: _____ DATE OF BIRTH: _____

ALLERGIES TO MEDICATION: (Please check the appropriate response)

☐ NO KNOWN DRUG ALLERGIES

☐ I AM ALLERGIC TO THE FOLLOWING MEDICATIONS: _____

_____

CURRENT MEDICATIONS & PHARMACY INFORMATION

Please list all of your medications, dosage (strength) and how often you take them each day

MEDICATION NAME	DOSAGE & FREQUENCY	REASON FOR USE	*FOR OFFICE USE Initial & Date

Please fill in the information below so we are able to send your EYE MEDICATIONS to the proper pharmacy.

Name of Local Pharmacy: _____ Phone: _____

Located in: _____ , TX on the corner of _____ & _____

(name of city) (street name) (street name)

Name of Mail Order Pharmacy: _____ Fax: _____

Mail order used for which type of prescription? ☐ 30 day ☐ 90 day

X _____ **DATE:** _____

PATIENT SIGNATURE