NORTHERN CALIFORNIA
RETINA VITREOUS ASSOCIATES
ESTABLISHED IN 1983

MEDICATION & ALLERGY LIST

Patient Name:_____ **DOB:**_____

Please list all **Eye Drops** you are taking:

Name	Right / Left / Both Eyes?	Frequency

Please list all **Medicines, Insulin, Blood Thinners, Vitamins, & Supplements** you are taking:

Name	Dose	Frequency

ALLERGIES

PREFERRED PHARMACY:

Name_____

Location _____

Phone _____