APEX EYE

MEDICATION / OVER THE COUNTER MEDICATION LIST

Please list ALL your RX MEDICATIONS and any other OVER-THE-COUNTER MEDICATIONS, including VITAMINS, you are taking.

NAME _____ **DOB** _____ **DATE** _____

PHARMACY _____ **PHONE#/ADDRESS** _____

*********Allergies:** _____

PLEASE PRINT

MEDICATION NAME	DOSAGE / FREQUENCY	REASON