Dear Patient or Caregiver, please list as much information as you can about all prescription or non-prescription medications, vitamins, or supplements that you take on a regular basis.

PATIENT NAME				PATIENT ACCT #	
				OFFICE USE ONLY	
Name of medication,eyedrop, supplement, or vitamin, whether prescription or non-prescription	What is the dose(amount) that you take?	How often do you take it?	How do you take it? (by mouth, injection, apply to skin, etc)	+/-	Reviewed date/initials