CLAY EYE PHYSICIANS & SURGEONS

NAME:____ DOB:_______________DATE:_____________

MEDICATIONS AND ALLERGIES: Please attach medication list if available.

Medication or Vitamins Name	Dosage	Reason for taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

DRUG ALLERGIES	REACTION
1.	
2.	
3.	
4.	
5.	