

MEDICATION SUMMARY SHEET

Patient Name

DOB

MR#

Date of Exam

PATIENT: PLEASE COMPLETE:

Pharmacy: _____ Telephone (____) _____

ALLERGIES: (Circle: NONE OR LIST BELOW)

- | | |
|----------|-----------------|
| 1. _____ | REACTION: _____ |
| 2. _____ | REACTION: _____ |
| 3. _____ | REACTION: _____ |
| 4. _____ | REACTION: _____ |

EYE DROPS/OINTMENTS	Dose/Frequency	Date Stopped	Reviewer/Date

MEDICATIONS (Prescription)	Dose/Frequency	Date Stopped	Reviewer/Date

OVER THE COUNTER	Dose/Frequency	Date Stopped	Reviewer/Date

DO YOU TAKE ASPIRIN? YES NO
 DO YOU TAKE BLOOD THINNERS? YES NO
 (Such as Plavix, Coumadin, or Other)
 DO YOU HAVE A PACEMAKER? YES NO

Reviewed with patient