Triangle Ophthalmology

Medication Sheet

Name:_____ Date of Birth: _____ Age:_____ Chart #:_____

For patients: Please complete a list of drug allergies, pharmacy info, medications and dosages. The rest of the form will be completed by the staff at your visit.

Please list all of your drug allergies and describe the reaction that you have to these medications:

_____

Current Pharmacy/Location/Phone #:_____

Date	Medication Name	Dosage/Usage	Discontinued	Tech/ MD