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