CENTER FOR SIGHT

MY LIST OF MEDICATIONS & DRUG ALLERGIES

Medical Record #: _____

Patient Name: _____ **Date:** _____

Preferred Pharmacy: _____

Pharmacy Address or Crossroads: _____

Current Medications: This list includes all prescribed medications, over-the-counter medications, vitamins and other supplements (herbal or non-traditional).

Medication Name	Dose (i.e. 100 mg)	Times / Day	Date Updated	Medication is Taken (oral, injections, topical, etc.)

Drug Allergies: This list includes all known drug allergies and type of reaction.

☐ No known drug allergies.

Medication Name	Type of Reaction

Medication Name	Type of Reaction