*For office use only*

**Medical Record #:** ____________

# RETINA ASSOCIATES OF KENTUCKY

## MEDICATION LIST

Name: ____________________________________ Date of Birth: _______________ Date: ______________

Pharmacy Name: ______________________________________________ Phone #: ________________________

☐ Check here if you have attached a comprehensive list of prescription and over the counter medications including eye drops. If not, please complete the sections below.

☐ Check here if you take a blood thinner and circle which one – Aspirin, Plavix, or Coumadin

| Medication Name | Dosage and Frequency Taken | For what condition are you taking this medication? |
|---|---|---|
| **Eye Drops** | | |
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| **Prescription Medications** | | |
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| **Over the Counter Medications** | | |
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***If you need more room, please write on the back of the page and check this box to notify staff*** ☐

| Allergies | |
|---|---|
| **Medication Name** | **Reaction** |
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