Cataract and Laser Center Central, LLC

Patient Medication and Allergy List

Patient Information:

Name: _____

Date of birth: _____

Today's Date: _____

Please list **ALL** medications you are currently taking, include any of the following:
Eye drops, vitamins, herbal supplements, "as needed" and over the counter medications.

MEDICATION	DOSAGE	FREQUENCY	1ST SURGERY	2ND SURGERY

ALLERGIES

Medication/Enviromental	Reactions

Patient/Guardian Signature_____ Date: _____

The above medications and allergies have been reviewed with the patient/guardian.

Nurse Signature 1st surgery _____ Date: _____

Nurse Signature 2nd surgery _____ Date: _____