Fishkind · Bakewell · Maltzman
Eye Care and Surgery Center

Date Reviewed	Tech	Dr
_____	____	____
_____	____	____
_____	____	____
_____	____	____

Date _____

MEDICATION/VITAMIN LIST

Patient Name _____

Please list all medications you are presently taking.

Name of medication	Dose	How often taken

☐ I am not presently taking any medications.

_____
Patient Signature