

Northern Illinois Retina

MEDICATION LIST

Name: _____ Birthdate: _____ Date: _____

CURRENT MEDICATIONS (including vitamins, aspirin & OTC)	DOSE (i.e. mg)	TIMES PER DAY (i.e. 3 times daily, etc.)	Office use only. Med changes	Office use only. Date of review	Office use only. Date of review

Are you currently taking any blood thinners such as Aspirin, Plavix or Coumadin? _____

ALLERGIES TO MEDICATIONS (including latex & adhesive tape) AND REACTIONS:

Primary Care Physician: _____ Phone #: _____

Specialist: _____ Phone #: _____

Ophthalmologist: _____ Phone #: _____

Optometrist: _____ Phone #: _____