Cape Fear Eye Associates, P.A.

Name____ Date____________________________

Medication Sheet

Please list medications you are using at present in the spaces provided below:

EYE MEDICINES				ALL OTHER MEDICINES		
Name	Dose	Freq.	Eye	Name	Dose	Freq.

Are you allergic to any medications or foods? Yes_____ No_____

If yes, please describe substance(s), with type or reaction: ____________________________________