

Northern California Retina-Vitreous Associates

MEDICATION & ALLERGY LIST

Patient Name: _____ **DOB:** _____

Please list all **Eye Drops** you are taking:

Name	Right / Left / Both Eyes?	Frequency

Please list all **Medicines, Insulin, Blood Thinners, Vitamins, & Supplements** you are taking:

Name	Dose	Frequency

ALLERGIES