EYE GROUP OF CONNECTICUT, LLC

PATIENT MEDICATION LIST

DUE TO FEDERAL REQUIREMENTS, WE ASK THAT YOU PROVIDE US WITH A LIST OF YOUR CURRENT MEDICATIONS:

IF YOU HAVE YOUR OWN Medication LIST, PLEASE bring with you to your appointment so that may have a copy in your records. Your list must *include all of the information requested below:*,

		How do you administer this/these medication?			How many **times/day** do you take this dose?
Name of Medication/ Supplement	Dose	Eye drops/ ointments (Check here)	Pill/Tablet (Check here)	Injections (Check here)	
		CHECK THE APPROPRIAT BOX BELOW:			
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
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		☐	☐	☐	

Reviewed by:_____ Date:_____

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Office Use Only:

Reviewed by:_____ Date: _____ No changes: □ Changes as noted above □

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Reviewed by:_____ Date:_____ No changes: □ Changes as noted above □