

**Northern California Retina-Vitreous Associates**

**MEDICATION & ALLERGY LIST**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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

<b>Name</b>	<b>Right / Left / Both Eyes?</b>	<b>Frequency</b>

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

<b>Name</b>	<b>Dose</b>	<b>Frequency</b>

<b>ALLERGIES</b>