Patient Name_____Date of Birth_____Today's Date_____

MEDICATION ALLERGIES Do you have any known medication allergies? ☐ YES ☐ NO

Medication/Reaction _____

_____

CURRENT EYE MEDICATIONS (PRESCRIBED AND OVER THE COUNTER)

Name of medication	Eye(s)	Frequency
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____
_____	Right Left Both	_____

CURRENT MEDICATIONS (PRESCRIBED AND OVER THE COUNTER)

Name of medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHANGES IN MEDICAL CONDITION (PLEASE NOTE ANY CHANGES IN YOUR HEALTH SINCE YOUR LAST EXAM)

Medical condition, surgery, hospitalization	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHYSICIAN SIGNATURE

_____	_____	_____	_____
Matthew P. Traynor, MD	Date	Kyle G. Thompson, MD	Date
_____	_____	_____	_____
Jason G. Hooton, MD	Date		Date