Current Medications / Vitamins / Supplements : Please list any other medications / vitamins or supplements you are taking:

medication / vitamin / supplement	amount	how often

Current Eye related Medications :

Medication	which eye (Circle One)	how often
	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	

Changes in health:
If you have had any new medical conditions, surgeries or hospitalizations since your last exam, please list them.

Date	Medical condition, surgery, hospitalization

Physician signature:

Physician signature	Date	Physician signature	Date