The Wright Eye Center, P.C.

Patient's Name: _____ Date:_____

Date of Birth: _____

Medications currently taking (including all non-prescription, over-the-counter, vitamins and herbal):

Name of Medication	Current Dose	Route	Reason for taking?	How Often?

Please list any allergies you might have or ☐ I HAVE NO MEDICATION ALLERGIES

Allergy	Describe your allergic reaction	Severity

ALLERGIC TO LATEX: ☐YES ☐NO **ALLERGIC TO TAPE/ADHESIVE: ☐YES ☐NO**

By signing this form I verify that there have been no changes or I have made the correct changes to my current medications/allergies:

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date