Eye Center of Central Maine (207) 873-6048

Medication List

Patient Name: _____ Date Started: _____

Date of Birth: _____ Acct #: _____

Medication Allergies: If you are allergic or sensitive to any medications, please list them here.

Medication List: Please tell us about any you are currently taking. Provide as much information as you can.

Medication	Dosage	Frequency	Condition
Example: Aspirin	Baby Aspirin	1 / day	Heart

If you would like a copy of this list for your records, please ask us to photocopy for you.

Patient: Please initial and date each time this form is reviewed and/or updated.

Technician/Doctor: Please initial and date each time this form is reviewed and/or updated.