The Wright Eye Center, P.C.

Patient to please complete <u>THIS SIDE ONLY</u>

Patient's Name: _____ Date: _____

Medications currently taking:

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

Please list Vitamins, Supplements, and Herbals that you are taking:

Name of Product	Amount Taken	Route	Reason for taking?	How Often?

Please list any allergies you might have:

Allergy	Describe your allergic reaction	Severity

☐ **I HAVE NO MEDICATION ALLERGIES**

ALLERGIC TO LATEX: ☐ **YES** ☐ **NO**

REACTION TO THE USE OF TAPE/ADHESIVE: ☐ **YES** ☐ **NO**