Milam's
COMMUNITY EYE CARE
770 483-4831

NAME: _____

DATE OF BIRTH: _____

DATE: _____

PERSONAL MEDICATION LIST

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Over-the-Counter Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Do you have any drug allergies? ☐ **YES** ☐ **NO**

If Yes please list: _____

_____

_____