SOMERSET OPHTHALMOLOGY
2877 Crooks Rd., Suite B • Troy, MI 48084
Ph. 248-822-7003 • Fax 248-822-7008

Patient Name: _____

Allergies: _____ Date: _____

MEDICATION FORM: Please fill out this form with all the medication you take. Example: prescriptions, samples, vitamins, nutraceuticals, over-the-counter drugs, vaccines, diagnostic and contrast agents, radioactive meds, respiratory therapy related meds, parenteral nutrition, blood derivatives and IV solutions, and any product designated by the FDA as a drug.

MEDICATION	DOSE	HOW OFTEN	WHAT IS THE DRUG USED FOR?
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☐ Change in Medication _____ Date _____ Tech _____