





# Digby Eye Associates

Please list **ALL MEDICATIONS** you are currently taking, including Aspirin.

I am not taking any medications at this time. Date: \_\_\_/\_\_\_/\_\_\_

Name	Strength	How often	Name	Strength	How often

Are you **ALLERGIC** to any medications? YES NO If yes, please list: \_\_\_\_\_

Physician Signature \_\_\_\_\_

**\*Doctor Use Only Below This Line\***

**UPDATES**

Date \_\_\_/\_\_\_/\_\_\_     No Changes     Updates \_\_\_\_\_ Reviewed by \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_     No Changes     Updates \_\_\_\_\_ Reviewed by \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_     No Changes     Updates \_\_\_\_\_ Reviewed by \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_     No Changes     Updates \_\_\_\_\_ Reviewed by \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_     No Changes     Updates \_\_\_\_\_ Reviewed by \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_     No Changes     Updates \_\_\_\_\_ Reviewed by \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_     No Changes     Updates \_\_\_\_\_ Reviewed by \_\_\_\_\_