Medication Reconciliation

Patient Name: _____ Date of Birth: _____

Phone: _____

Please list any medications you take, including vitamins and supplements:

Medication	Dosage	How Often	Last Dose (Office Use Only)

Please list any allergies you have:

Allergy	Reaction

Patient Signature: _____

Date: _____

DOCTOR Signature:

_____

For Surgery Center Use Only

Annual Patient Update Form

Patient Name: _____ Date of Birth: _____

Pharmacy: _____ Primary Care Physician: _____

HISTORY

Have there been any changes to your medical history? ☐Yes ☐ No

Please list all changes:

_____

_____

_____

Have there been any changes to your eye history? ☐Yes ☐ No

Please list all changes (including new glasses or contacts):

_____

_____

_____

Tobacco Use? ☐Yes ☐ No

If YES, How Much? _____
(Includes Smoking, Chew, Vape)

Do you drink Alcohol? ☐Yes ☐ No

If YES, How Much? _____

Please list any eye drops you are currently using:

Eye Med	How Much/Often?

Patient/Guardian signature indicates the above information is complete and accurate:

_____

Patient (or person authorized to sign patient) Date