Please complete ALL columns **Bring to surgery center**

PATIENT MEDICATION LIST

Medications and Supplements	Dosage	Frequency	Last Dose 1st eye/2nd eye	Reason for Medication
			/	
			/	
			/	
			/	
			/	
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			/	
			/	
			/	

ALLERGY & REACTION (Include over the counter meds and foods)

Verified by: _____ Date: _____

Continue medicatons as ordered by primary physician.
We will discuss any medications held for surgery during follow up appointment.

_____
Surgeon Signature

Revised 5/02/2016

Carroll County
Surgery Center