Orange County Ophthalmology
12665 Garden Grove Blvd, Suite 401
Garden Grove, Ca 92843

Patient's Name: _____
Patient's Acc. #: _____

Patient Medication Record

Include ALL OTC, Patches, Inhalers, Vitamins, Herbs

MEDICATIONS	DOSE	FREQUENCY

Information obtained from: ☐ **Patient** ☐ **Family** ☐ **Dr's Office** ☐ **H&P**
Form Completed by _____

☐ **Additional medication instructions:** _____
_____

KEEP A LIST OF YOUR CURRENT MEDICATIONS AND TAKE IT WITH YOU FOR ALL YOUR DOCTOR VISITS, SURGERY CENTERS AND HOSPITAL VISITS. INFORM ALL HEALTHCARE PROVIDERS OF ANY ALLERGIES.

For Office Use: Annual Updates:	**YES**	**NO**	**IF YES, Explain**	**Initials**
Changes in General Health	☐	☐ _____ Date	_____	_____
	☐	☐ _____ Date	_____	_____
	☐	☐ _____ Date	_____	_____
	☐	☐ _____ Date	_____	_____