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Patient Medication / OTC Form

Name (Last, First): ______________________________

Birthday (Month/Day/Year): ______________________________

Medications: ❑ None

Type	What for

OTC / Supplements: ❑ None

Type	What for

Eye Drops: ❑ None

Type	What for

Allergies: ❑ None Medications	Allergies: ❑ None Food, Environmental, Latex, etc.

Tobacco use: Yes   No

If yes, amount per day: _________________________

Recreational Drug use: Yes   No

If yes, type and amount: _________________________

Current medical or visual diagnosis:

(ie. diabetes, autism, sensory processing, traumatic brain injury (concussion/sports concussion, etc.), obsessive compulsive disorder, anxiety, depression, high cholesterol, high blood pressure, etc.)(please avoid acronyms and write out diagnosis)

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Doctor's Intitials_________________ Date__________________