QUINLAN
EYE SURGERY
& LASER CENTER

MEDICATION LIST

Please list all prescription, non-prescription medications, over-the-counter medications and herbal medications

Medication	Usage	Route (example: by mouth, nasally, eye drop, injectable)

HAVE YOU EVER HAD A NEGATIVE REACTION TO ANY ANESTHETIC ❑ Y ❑ N

If yes, please describe:

_____

_____

Please list any medication allergies:

_____

_____

Pharmacy _____ Phone number _____

Patient Signature _____ Date _____