QUINLAN
EYE SURGERY
& LASER CENTER

Medications List

Dr. Quinlan needs to know all medications you are using. Please tell us how many times a day or week and how long you have been using each medication.

Please include non-prescription medications such as Tylenol®, aspirin, Advil®, etc.

Medicine	Usage	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a negative reaction to any anesthetic? ❑ Y ❑ N

If yes, please describe _____

Please list any allergies:

_____

_____

Pharmacy _____ Phone Number _____

Your Signature: _____ Date: _____

Reviewed and updated with patient:

Date _____ Initial _____ Date _____ Initial _____

Date _____ Initial _____ Date _____ Initial _____

Date _____ Initial _____ Date _____ Initial _____

Date _____ Initial _____ Date _____ Initial _____