Fishkind & Bakewell
Eye Care and Surgery Center

FISHKIND & BAKEWELL EYE CARE
MEDICATION LIST

Date Reviewed	Tech	MD/OD
_____	____	____
_____	____	____
_____	____	____
_____	____	____
_____	____	____

Patient Name: _____

Please list all medications you are currently taking.

Name of medication Dose How often taken_____

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□ I am presently not taking any medications.

_____
Patient Signature