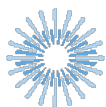


Please complete and return by mail as soon as possible.



**Boston Foundation for Sight  
Medication List**

Directions: Enter all medications you take, including those that are sold to you without a prescription. You may want to **ask your pharmacy for a printout of your meds** instead.

Name: \_\_\_\_\_  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Zip Code: \_\_\_\_\_

Medication allergies:

Medication	Dose/Amount	How often	Condition/Reason for Med	If change, ✓ & date
<i>Enter meds not for your eyes here: Example: Lisinopril</i>	<i>20 mg</i>	<i>1x/day</i>	<i>High blood pressure</i>	
<i>Enter your eye meds here: Example: Timolol</i>	<i>0.50%</i>	<i>1x/day ea eye</i>	<i>Glaucoma</i>	

Doc Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Recorded by: \_\_\_\_\_  
 Doc Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Recorded by: \_\_\_\_\_  
 Doc Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Recorded by: \_\_\_\_\_