Please complete and return by mail as soon as possible.

Boston Foundation for Sight

Medication List

Name: _____

DOB: _____/_____/_____

Address: _____

_____

Zip Code: _____

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.*

Medication allergies:

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

Doc Signature: _____ Date: _____ Recorded by: _____

Doc Signature: _____ Date: _____ Recorded by: _____

Doc Signature: _____ Date: _____ Recorded by: _____