Schwartz Laser Eye Center

Patient Name_____ Date of Birth_____ Date_____

Please indicate your allergies, reaction and the names of all medication you take along with strength, frequency, and reason for the medication.

Allergy	**Reaction** (skin rash, hives, itching, fever, swelling, runny nose, shortness of breath, ect.)

Medication	**Strength**	**Frequency**	**Reason**

Doctor Name	**Physician Type** (PCP, Cardiologist, ect.)	**Practice Name / Address**	**Phone Number**
PHARMACY:	**Phone:**	**Location:**	

This Box for Office use only

Updated as of _____ Signed off by_____

Changes to be made_____

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