PAJKA EYE CENTER

Tech. Name/Date_____

NAME _____ DATE _____

MEDICATION ALLERGIES:

NAME **TYPE OF REACTION** : rash, hives, breathing, etc

_____
_____
_____
_____
_____
_____

ANY ALLERGIES TO:

LATEX YES NO

If yes, explain_____

_____

IODINE YES NO

If yes, explain_____

_____

_____

PLEASE LIST ANY MEDICATIONS, HERBS, VITAMINS & EYE DROPS YOU TAKE (include over the counter)	DATE								
NAME MGS x a day	TECH								

John T. Pajka, MD (JTP)
Brian W. Chinavare, MD (BWC)
Robert J. Derick, MD (RJD)
Adam M. Nusgart, OD (AMN)

MD initials review and confirm medication updated.