NY Eye & Ear Infirmary

Continuum Health Partners, Inc.

THE NEW YORK EYE AND EAR INFIRMARY

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MY MEDICATION LIST

***BRING THIS FORM WITH YOU ON THE DAY OF PRE ADMISSION TESTING AT NYEEI OR YOUR DAY OF ADMISSION**

***Please bring your medication with you, keep them in their original containers.**

A record of your current medications is important to provide safe and effective care.

PATIENT NAME

DATE OF ADMISSION

DATE OF BIRTH

Do you have Allergies to Medication? ☐ NO ☐ YES If yes list allergies

List all of the medications that you are currently taking. Include: eye drops, inhalers, contraceptives, patches that contain medication, over-the-counter medication, dietary and herbal supplements.

Name of medication(s)	Dose strength: (milligrams, units, drops, etc.)	How many times a day do you take this medication ?

(Print the name of your Medical Doctor) (Phone #)

(Name and relationship of the person who assisted you in completing this form) (Phone #)

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