Kerrville Eye Center, P.A.
Russell S. Cravey, M.D.

MEDICATION LIST

Patient Name: ___________________________________

Instructions: Please list all medications including prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements taken on a regular basis. Include medicated patches and topicals.

Medication Name	Dosage	Frequency and Route (circle Route)
		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch
		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch
		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch
		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch
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		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch
		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch
		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch
		__time(s)/day Oral/Inhaler/Inject/Sublingual/Topical/Patch

Confirmed by: ____ Date: _______________