MEDICATION / VITAMIN /EYE DROP LOG

Name: _____ Date: _____

Date prescribed	Physician	Medication	Dosage	Administration (Times/day)

Primary care doctor: _____

Preferred pharmacy: _____

Allergies (include medication allergies): _____

_____

Please mark the follow that you **can** take:

Aspirin___ Novocain___ Barbiturates (sleeping pills)___ Codeine___ Narcotics___ Penicillin___ Sulfa___