

**Pendleton Family Optometry  
765-778-7524**

**Patient List of Medications/Allergies**

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Please list all of your medications, including any over-the-counter supplements. Please include prescribing information, such as dosage and how prescribed.

**Also, please list provider who prescribed your medication.**

**MEDICATIONS:** \_\_\_\_\_

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**ALLERGIES:** \_\_\_\_\_

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