ALASKA VISION CENTER, INC.
A MEMBER OF VISION SOURCE®

Dr. Jill Geering Matheson, OD • Dr. Sarah Bixby-DuBois, OD

Patient:_____ Date:_____

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, liquids etc . Include prescription, over-the-counter, herbal, vitamin and diet supplement products. Also list any medicine you take only on occaision.

Medication Name	**Dose** (ie how many mg/mcg/ml etc?)	**How and How often do you take it?**	**Taken for what?**	**Who told you to take it/prescribed it?**
Example: Lisinopril	*Example: 10mg*	*Example: By mouth once a day*	*Example: Hypertension*	*Example: Dr. John Doe*

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