KELLIS EYE & LASER CENTER

Medication & Physician Update

Date _____

Patient Name _____

Primary Care Physician _____

PCP Phone Number _____

Cardiologist _____

Cardiologist Phone Number _____

Allergies & Reactions _____

_____

Do you take Flomax? YES NO

Do you take blood thinners? YES NO If yes, which one? _____

Medication	Dosage	Date/Initials	Prescribing Dr