New York Eye and Ear Infirmary of Mount Sinai

THE NEW YORK EYE AND EAR INFIRMARY

MY MEDICATION LIST

***BRING THIS FORM WITH YOU ON THE DAY OF:** **PRE ADMISSION TESTING AT NYEEI** ❑
YOUR DAY OF ADMISSION ❑

***Please bring your medication with you. Keep them in their original containers.**
A record of your current medications is important to provide safe and effective care.

PATIENT NAME _____

DATE OF ADMISSION _____ DATE OF BIRTH_____

Do you have Allergies to Medication? ❑NO ❑YES If yes, list allergies _____

_____

List all of the medications that you are currently taking. Include: eye drops, inhalers, contraceptives, patches that contain medication, over-the-counter medication, dietary and herbal supplements.

Name of medication(s)	Dose strength: (milligrams, units, drops, etc.)	Times of day you take this product

_____
Print the name(s) of your Medical Doctor(s) Phone Number(s)

_____
Print the name of your Pharmacy or Pharmacies Phone Number(s)

_____
Name and relationship of the person who assisted you in completing this form Phone Number