Retina Center Of Pensacola

MEDICAL INFORMATION

NAME: _____ **DATE**: _____

Please carefully complete this form. Thank You.

List all current medications and dosage, including herbs/supplements/over-counter medications

List all medical problems, include when problems began.	**List all past surgeries and year performed**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
List all known allergies (Drug and Food related)	
Do you have any pets? What kind?	

Patient's Signature_____ Date: _____

Aref Rifai, M.D ._____ Date: _____