BOSTON EYE CARE CONSULTANTS

Robert A. Lytle, MD

MEDICATION LIST

PATIENT LABEL

* If you have a list of current medications and dosages, we will be happy to copy them for you, otherwise please list all medications that you are currently taking. Please include over the counter medications.

Name of Medication	Dosage	How often	Reason

(Continue on back side of page if needed)

*Patient Signature:______________________Date:__________Technician Initials:__________