ST LOUIS EYE SURGERY & Laser Center

Patient Name: _____

DOB: _____

PATIENT LABEL/STICKER

Home Medication List

Please carefully list the medications you are currently taking along with the dosage, frequency, and your reason for taking the medication. By signing below, you are stating that this information is current and accurate.

Medication Name	Dose	Frequency	Reason Taken

Patient or Responsible Party Signature

Date