Diabetes Information

OPHTHALMIC SPECIALISTS OF MICHIGAN

Patient Name: _____ **DOB:** _____

Primary Care Doctor: _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

Most Recent A1C: _____

(Example: 5.7% - 9.1% This is a common blood test completed by the Physician managing your diabetes care. If you do not know this, please bring your most recent blood work with you to your appointment.)

Please list any allergies you may have and your reaction: _____

_____

Please review the medication list below. Add any prescription drugs, over-the-counter medications, vitamins and supplements that you are currently taking.

Medication Name	Dose	Route (by mouth, eye drops, inhaler, etc.)	How often do you take this medication?	Reason you are taking this medication?