<table>
<thead>
<tr>
<th>Patient Identifier (confidential):</th>
<th>Gender:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected Ocular or Systemic Reaction:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Days/Months to Onset of Side Effect:</td>
<td>Outcome:</td>
<td></td>
</tr>
<tr>
<td>Relevant Tests/Lab Work:</td>
<td></td>
<td></td>
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<tr>
<td>Suspected Drug: (Generic name preferred)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily Dose:</td>
<td>Route of Administration:</td>
<td></td>
</tr>
<tr>
<td>Indication for Use:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the reaction disappear if the drug was stopped?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other Relevant History:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Contact Information: (optional, but encouraged)</td>
<td>Name:</td>
<td>Email:</td>
</tr>
</tbody>
</table>