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Patient's Name: ____ Date: ____________
(Last) (First) (MI)

Family Doctor: ___________________________________ Tel #: ________________

PERSONAL MEDICAL HISTORY:
Please indicate whether you have (or are being treated for) any of the following medical problems

____Myocardial Infarction (Heart attack)
____Hypertension (High blood pressure)
____High cholesterol
____Diabetes
____Stroke
____Thyroid problem
____Arthritis (Joint trouble)
____Migraine headaches
____Cancer (Type_______________________)
____Coagulation (Bleeding/Clotting) Disorder
____Other Medical Conditions _______________
____

PERSONAL EYE HISTORY:
Please indicate whether you have (or are being treated for) any of the following ocular problems

____Glaucoma (high pressure in eyes)
____Cataracts
____Macular Degeneration
____Diabetic Eye Disease
____Eye Surgery__________________________
____Other Eye Problems___________________

ALLERGIES TO MEDICATIONS:____

NAMES OF MEDICATIONS (Prescription/non-prescription, vitamins, birth control, herbal):

____

____

____

HAVE YOU <u>EVER</u> TAKEN THE FOLLOWING MEDICATIONS:

Flomax (Tamsulosin) Y N
Other Prostate Medications Y N If yes, please list: ___________________________

FAMILY MEDICAL HISTORY:
Please indicate whether there is a family history of the following

____Glaucoma
____Macular Degeneration
____Hypertension
____High cholesterol
____Diabetes
____Stroke
____Thyroid problem
____Migraine headaches
____Arthritis (Joint trouble)
____Other Medical Conditions_______________
____

ARE YOU ALLERGIC TO LATEX? Y N

ARE YOU PRESENTLY PREGNANT? Y N