Patient name: _____

Brumm Eye & Laser Vision

Office Use Only

Please List ► CURRENT MEDICATIONS:

Have you ever taken FLOMAX? □ YES □ NO

Please List ► MEDICATION ALLERGIES / DRUG ALLERGIES **□ No Known Allergies**

_____
Patient signature

_____
Date

Dated: 1/27/2010; cmt; updated: 2/01/2010--cmt