OHIO OPHTHALMOLOGY

Name:_____ Date of Birth:_____

Optometrist: _____ (who does your glasses)

Height: _____ Weight:_____

Family History:

Glaucoma YES NO

If yes, what relationship_____

Diabetes YES NO

If yes, what relationship_____

Macular Degeneration YES NO

If yes, what relationship_____

Have you ever taken FLOMAX? YES NO

If yes, are you taking it now? YES NO

Are you allergic to Adhesive tape? YES NO

Are you allergic to Latex? YES NO

Eye Surgery YES NO

Eye trauma/injury YES NO

If yes, please explain_____