FOCAL POINT VISION
MEDICATION LIST

Patient Name: _____ DOB: _____/_____/_____

Please list all medications, vitamins or supplements that you are **currently** taking.

DRUG NAME:	DOSAGE:	PER:

PHARMACY INFORMATION

Pharmacy Name: _____ ( ) Local ( ) Mail Order

Address: _____ City/State/Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Have you EVER used: Flomax (tamulison) Avodart (dutasteride) Alfuzsin(uroxatral) Proscar (finasteride)
Circle **YES** Only

DRUG ALLERGIES

DRUG NAME:	REACTION:

Date: _____