REFRACTIVE SURGERY PATIENT HISTORY

The collection of information is governed by the Authority, Purpose and Routine Uses Identified in DD Form 2005, Privacy Act Statement - Health Care Records.

1. PATIENT NAME (Last, First, MI)	2. DATE	3. DOD CAC ID

REFRACTIVE HISTORY

4. How many years have you worn glasses?	5. How many years have you worn contact lenses?	6. How old is your current glasses prescription?

7. When did you last wear contact lenses?	8. Do you or have you ever worn bifocals?	9. Have you ever had difficulty with contact lens wear? Describe

10. CONTACT LENS TYPE: ☐ Soft ☐ Rigid Brand: _____

11. ALLERGIES Do you have any allergies to medications? ☐ NO ☐ YES

Please list medication and reaction. _____

12. OCULAR SURGERY Have you ever had surgery or laser treatments on your eyes? ☐ NO ☐ YES

Specify _____

13. OCULAR HISTORY Do you have any of the following eye problems?

Amblyopia/Lazy Eye	☐ NO ☐ YES	Cataracts	☐ NO ☐ YES	Conjunctivitis, recurrent	☐ NO ☐ YES
Corneal Ulcer	☐ NO ☐ YES	Double Vision	☐ NO ☐ YES	Dry Eyes	☐ NO ☐ YES
Glaucoma or High Eye Pressure	☐ NO ☐ YES	Herpes Simplex/Zoster	☐ NO ☐ YES	Keratoconus	☐ NO ☐ YES
Retinal Problems	☐ NO ☐ YES	Trauma	☐ NO ☐ YES		
Other	☐ NO ☐ YES	Specify _____			

14. MEDICAL HISTORY Do you or have you ever had the following?

Arthritis	☐ NO ☐ YES	Breathing Problems	☐ NO ☐ YES	Diabetes	☐ NO ☐ YES
Heart Problems	☐ NO ☐ YES	High Blood Pressure	☐ NO ☐ YES	Migraine Headaches	☐ NO ☐ YES
Pacemaker	☐ NO ☐ YES	Immunosuppression/HIV	☐ NO ☐ YES		
Other Medical Problems	☐ NO ☐ YES	Specify _____			

15. MEDICATIONS Are you taking any of the following?

Accutane (Isotretinoin)	☐ NO ☐ YES	Birth Control Pills	☐ NO ☐ YES	Cordarone (Amiodarone)	☐ NO ☐ YES
Immunosuppressants	☐ NO ☐ YES	Imitrex (Sumatriptan)	☐ NO ☐ YES	Steroid Medication	☐ NO ☐ YES

List other medications you are currently taking: _____

16. PATIENT SIGNATURE	17. DATE

18. TECHNICIAN COMMENTS Web Sites Provided ☐ NO ☐ YES VISX Booklet Provided ☐ NO ☐ YES Consent Form Provided ☐ NO ☐ YES

Convalescent Leave Form Provided ☐ NO ☐ YES

19. TECHNICIAN NAME (Last, First, MI)	20. TECHNICIAN SIGNATURE	21. DATE

22. PHYSICIAN COMMENTS

23. PHYSICIAN NAME (Last, First, MI)	24. PHYSICIAN SIGNATURE	25. DATE

26. FOR OFFICIAL USE ONLY

WILFORD HALL AMBULATORY SURGICAL CENTER REFRACTIVE SURGERY PATIENT INFORMATION

The collection of information is governed by the Authority, Purpose and Routine Uses Identified in DD Form 2005, Privacy Act Statement - Health Care Records.

1. PATIENT NAME (Last, First, MI)	2. OCCUPATION	3. AFSC	4. DATE

5. GRADE	6. MARITAL STATUS	7. DOD CAC ID	8. DATE OF BIRTH (MM/DD/YY)	9. SEX ☐MALE ☐FEMALE

10. DUTY ADDRESS (City, State, Zip Code, Country)

11. DUTY PHONE (DSN)	12. DUTY PHONE (Commercial)	13. DUTY EMAIL

14. STATUS

☐Active Duty ☐Reserve ☐Retiree ☐Dependent ☐Other _____

15. SERVICE ☐Air Force ☐Army ☐Navy ☐Marine Corps ☐Other _____	16. END OF ACTIVE SERVICE (MM/DD/YYYY)

17. HOME STREET ADDRESS (Apartment Number if applicable)	18. CITY	19. STATE

20. ZIP CODE	21. COUNTRY	22. HOME PHONE	23. HOME EMAIL

24. EMERGENCY CONTACT (Other than spouse)	25. RELATIONSHIP	26. PHONE

27. HOME STREET ADDRESS (Apartment Number if applicable)	28. CITY	29. STATE	30. ZIP CODE	31. COUNTRY

32. NAME OF EYE CARE PROVIDER	33. ADDRESS	34. CITY

35. STATE	36. ZIP CODE	37. COUNTRY	38. PHONE

39. YOUR INTERESTS (Check all that apply.)

☐Aerobics ☐Biking ☐Hiking ☐Family ☐Jogging ☐Movies ☐Reading ☐Shopping ☐Other _____

40. Amount of time you spend wearing glasses or contact lenses for your DISTANCE vision. ☐0% ☐< 25% ☐26-50% ☐51-75% ☐75-100%

41. What do you hope to achieve from having laser eye surgery? There can be no guarantee that glasses and contact lenses will no longer be necessary.

42. FOR OFFICIAL USE ONLY

Special Circumstances

Answer yes or no to each prompt.

	Yes	No
Armed Use of Force (AUoF) (Do you carry a weapon?)		
Personnel Reliability Program (PRP) (Do you work with nuclear weapons?)		
Are you on Flying Status?		
Are you in the Reserves or National Guard?		

Patient's Agreement

Follow Up Care Requirements

I understand that I must complete all required follow up appointments after surgery. At a minimum, these will take place 1 day, 1 week, 1 month, 3 months, 6 months, and 12 months after surgery. I understand that these appointments may be with my surgeon or with another doctor on the Refractive Surgery Team.

I am aware that I will be placed on “Duty Limiting Condition” status after surgery. I understand that I cannot deploy or PCS for at least 30 to 90 days (60-90 days for PRK, 30 days for LASIK/SMILE/ICL/RLE), and this mobility restriction may be extended depending on my healing. I understand that I must be evaluated by the Refractive Surgery Clinic prior to being cleared to resume unrestricted duties, PCS, or deploy.

Release and Consent for Ocular Imaging and Diagnostic Testing

I hereby authorize images to be taken for medical purposes. I agree to the use of the negatives, prints, copies, or reproductions for insurance documentation, monitoring of my condition, teaching, and publication for educational purposes.

Anticipatory Guidance

I understand that my appointment may last 2-3 hours. I will be dilated. The dilation may last 24-72 hours. I need to bring a driver if I suspect I will not be comfortable driving while dilated. On the day of surgery, unless I will be staying at the Fisher House (walking distance), I will need a driver/escort to and from the Refractive Surgery Center. I understand that children are not permitted in Refractive Surgery Clinic or at the Refractive Surgery Center.

By signing below, I certify that I have answered the “Special Circumstance” prompts truthfully, and that I agree to, and will comply with, the above “Patient’s Agreement.”

_____ _____

Applicant’s Name Electronic Signature