Travis AFB Warfighter Refractive Eye Surgery Program (WRESP) Center Patient Information and Medical History Form

David Grant Medical Center, 60th Medical Group, WRESP Center |
Travis AFB, CA 94533 Contact: (707) 423-3146

Digitally complete all sections, do not leave any items blank. If a topic does not apply, enter "N/A."

Name (Last, First MI. Suffix): **DOD#:** **Date of Birth:** **Age:**

Sex: Male ☐ **Flyer** ☐ **PRP** ☐ **MEB** ☐ **Palace Chase:**

Deployment/TDY/PCS Date/Loc: **Date of Separation/Retirement:**

OCULAR HISTORY

Do you have or have you ever had the following eye conditions?

Amblyopia/ lazy eye	☐ NO	☐ YES
Cataracts	☐ NO	☐ YES
Conjunctivitis, recurrent	☐ NO	☐ YES
Ocular Rosacea	☐ NO	☐ YES
Double vision	☐ NO	☐ YES
Severe dry eyes	☐ NO	☐ YES
Glaucoma or high eye pressure	☐ NO	☐ YES
Ocular Herpes Simplex / Zoster	☐ NO	☐ YES
Keratoconus	☐ NO	☐ YES
Retinal problems	☐ NO	☐ YES
Trauma	☐ NO	☐ YES
Previous eye surgery or PRK/LASIK eval?	☐ NO	☐ YES

Explain any yes or indicate other eye condition not listed:

MEDICAL HISTORY

Do you have or have you ever had any of the following?

Psoriasis	☐ NO	☐ YES
Vitiligo	☐ NO	☐ YES
Rheumatoid arthritis	☐ NO	☐ YES
Ulcerative Colitis or Crohn's disease	☐ NO	☐ YES
Thyroid disease	☐ NO	☐ YES
Diabetes	☐ NO	☐ YES
Heart disease or pacemaker	☐ NO	☐ YES
Autoimmune disease	☐ NO	☐ YES
Migraine headaches	☐ NO	☐ YES
Fainted/light headed during eye exam	☐ NO	☐ YES

Other medical conditions not listed:

REFRACTIVE HISTORY

How many years have you worn glasses? _____

Do you wear or have you ever worn bifocals? _____

How many years have you worn contact lenses? _____

Soft or hard lenses? _____

Date you stopped wearing them? ***(required)*** _____

****discontinue use of contact lenses prior to first appointment****

(soft lenses: minimum 30 days, hard lenses: minimum 90 days)

Pregnant/Nursing in past 6 months ☐ N/A ☐ NO ☐ YES

or planning to become pregnant within 1 year? ☐ NO ☐ YES

MEDICATIONS

Are you taking or have you ever taken any of the following?

Accutane (isotretinoin)	Date: _____	☐ NO	☐ YES
Immunosuppressants	Date: _____	☐ NO	☐ YES
Migraine medication	Date: _____	☐ NO	☐ YES
Steroid medication	Date: _____	☐ NO	☐ YES
Cordarone (amiodarone)		☐ NO	☐ YES
TB meds (INH) within past 30 days		☐ NO	☐ YES
Smallpox vaccination within past 3 weeks		☐ NO	☐ YES

List all medications that you are currently taking:

(including any above)

What do you hope to achieve from having PRK/LASIK? Other comments you would like to share? Please type below.

Medication allergies? List drug and reaction: ☐ NO ☐ YES

How did you hear about us? Doctor

Patient signature: **Date:**

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