WARFIGHTER REFRACTIVE CENTER - TRAVIS AFB, CA 94535
usaf.travis.60-mdg.mbx.dgmclasercenter@health.mil Patient Information and Medical History Form

Please type ONLY. DO NOT LEAVE ANYTHING BLANK. If something does NOT apply type N/A. Incomplete forms will NOT be accepted.

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

Please choose ALL that apply:

Sex: Male

Branch of Service: Branch

☐ **Flyer** ☐ **PRP** ☐ **MEB** ☐ **Palace Chase/Front**

Status: Status

Deploying PCSing Date/ Location:

Rank: **Job Title:**

Date of Separation/Retirement: *(required)*

**** * Minimum Retainability Requirement: Air Force, Army (6 months); Navy, Coast Guard, Marine Corps, (12 months) * ****

Home Address: **Duty Base/Station:**

City, State, Zip: **State, Zip:** **Unit:**

Personal Phone: **Work Phone:**

Personal Email: **Work Email:**

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:

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

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

How did you hear about us? Doctor

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:

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)

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

Patient signature: **Date:**

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