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 Phone: (707) 423-3146

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

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DOD ID
JOB TITLE OR OCCUPATION	DATE OF BIRTH	AGE	SEX
			Select one
HOME ADDRESS	CITY	STATE	ZIP

Flyer ☐	PRP ☐	MEB or PEB ☐	AUoF ☐	Palace Chase ☐	N/A ☐

Are you scheduled for any upcoming deployments, TDY's, trainings, or a PCS? If yes, please list the dates and locations.	End of Active Service

OCULAR HISTORY Check Yes/No

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 Check Yes/No

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 ☐
Pregnant/Nursing in past 6 months	No ☐	Yes ☐
Planning to become pregnant within 1 year?	No ☐	Yes ☐

Other medical conditions not listed:

MEDICATIONS HISTORY Check Yes/No

Are you taking or have you ever taken any of the following?		
Accutane (isotretinoin) Date:	No ☐	Yes ☐
Immunosuppressants 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 over-the-counter (OTC) and any in the above list.

MEDICATION ALLERGIES Do you have any medication allergies?

Yes ☐ No ☐ If yes, list drug and reaction:

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)

ADDITIONAL INFORMATION

What do you hope to achieve from having PRK/LASIK?

COMPLETED BY PATIENT

SIGNATURE	DATE