RESET FORM (CLEAR ALL ENTRIES)

TAMC LASER REFRACTIVE SURGERY CENTER
PATIENT QUESTIONNAIRE

OFFICE USE ONLY	Ticket #
Appt Date:	@

Please fill out completely:

Date:_____ DOD ID #: _____

Name:_____Rank/Grade:_____Branch: _____
(Last) (First) (MI)

Age: ____ Date of birth: _____ Gender: ☐ Male ☐ Female
DD / Month / YY
(Example: 01 Jan 80)

MOS/Occupation:_____ Unit:_____

Home Address: _____

Phone number: Home:_____Work:_____
Cell: _____
Email address: _____

Are you going on any type of Training, Leave, or Deployment?
Training/Underway_____
Leave_____
Deployment _____

Are you undergoing a medical board or disability evaluation **or on LIMDU?** ☐ Yes ☐ No

Are you going to PCS in the next 12 months? ☐ Yes ☐ No When? _____

In your own words, please list what your expectations are for refractive surgery:
Example: *To be able to wake up in the morning and see the clock.*

1. _____

2. _____

Military Duties:	Yes	No
Are you involved in or expecting to apply for flight status or special operations?	☐	☐
Are you involved in or expecting to apply for submarine/undersea duty?	☐	☐
Are you deploying to a combat zone within the next TWELVE months?	☐	☐

If so, estimated date deploying? _____

Name:_____Date of birth:_____ Last 4:_____
(Last) (First) (MI) (Example: 01 Jan 80)

Medical and Ocular History:

How long have you worn glasses?_____years, since age _____

How old are the glasses you are wearing? _____

How long has your eyeglass prescription been unchanged? _____

Have you ever worn contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

What type of contact lenses do you wear? ☐ Soft Lenses ☐ Hard / Rigid Gas Permeable Lenses

Date contacts were last worn? _____

** CONTACT LENS WEAR MUST BE DISCONTINUED AT LEAST 30 DAYS PRIOR TO FIRST APPOINTMENT **

Do you have dry eyes?

☐ 0 - None ☐ 1- Minimal ☐ 2 - Mild ☐ 3 - Moderate ☐ 4 - Severe ☐ 5 - Extreme

Do you have glare or halos?

☐ 0 - None ☐ 1- Minimal ☐ 2 - Mild ☐ 3 - Moderate ☐ 4 - Severe ☐ 5 - Extreme

Quality of vision without correction during:

Daytime: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Nighttime: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Overall satisfaction of your vision:

Without Correction: ☐ Very Satisfied ☐ Moderately Satisfied ☐ Mildly Satisfied ☐ Dissatisfied

With glasses: ☐ Very Satisfied ☐ Moderately Satisfied ☐ Mildly Satisfied ☐ Dissatisfied

With contacts: ☐ Very Satisfied ☐ Moderately Satisfied ☐ Mildly Satisfied ☐ Dissatisfied

List all medications or supplements you take regularly:

List any allergies (medication, food, seasonal) that you have:

FEMALES:

	YES	NO
Are you pregnant or have you been pregnant in the last 6 months?	☐	☐
Have you been breastfeeding in the past 6 months?	☐	☐

Name:_____Date of birth:_____Last 4:_____
(Last) (First) (MI) (Example: 01 Jan 80)

Has a doctor ever told you that you have? (If you don't know what it is, just skip it.)

Yes	No	
☐	☐	1. Corneal disease?
☐	☐	2. Glaucoma / High eye pressure?
☐	☐	3. Amblyopia / Lazy eye?
☐	☐	4. Retinal problems?
☐	☐	5. Recurrent eye inflammation or uveitis?
☐	☐	6. Herpes infection in your eyes?
☐	☐	7. Keratoconus / Progressive corneal thinning?
☐	☐	8. Cataract?
☐	☐	9. Eye injury?
☐	☐	10. Eye infection?
☐	☐	11. Eye ulcer?
☐	☐	12. Eye surgery, including PRK or LASIK?
☐	☐	13. Diabetes?
☐	☐	14. Autoimmune disease?
☐	☐	15. Keloid formation?
☐	☐	16. Immune compromise?
☐	☐	17. Skin eczema / Atopy / Allergies?
☐	☐	18. Accutatne, Amiodarone, or Imitrex use?
☐	☐	19. Other medical conditions?

If YES to any of the above, explain here.