Reset Form

TRIPLER ARMY MEDICAL CENTER
Refractive Surgery Clinic | (808) 433-3089

Refractive Surgery Patient Questionnaire

Office Use Only: Ticket # _____
Rodeo Date: _____
Appt Date: _____@ _____

PATIENT INFORMATION

Name *(Last, First, MI)*: _____ DOB: _____ Age: ____

Gender: ☐ M ☐ F DOD ID: _____

Active Duty / AGR / Reserve *(circle one)* Rank: _____ Branch of Service *(circle one)*: USA USAF USN USMC USCG USPHS

Mailing Address: _____

Telephone Numbers: Work: _____ Cell: _____

Military Email (.mil): _____

Unit of Assignment: _____ Occupational Specialty: _____

Are you being deployed? ☐Yes ☐No Date of deployment:_____ETS Date: _____ PCS Date: _____

Training / TOY / Leave Dates:_____

Pending Disciplinary Action or Medical Evaluation Board (MEB) or on LIMDU?: ☐Yes ☐No

Have you been previously screened at Tripler for Refractive Surgery? ☐Yes ☐No

I, *(print name)* _____ , am a full-time active duty service member assigned to an active duty tenant unit stationed on Hawaii. I am NOT on active duty orders as mobilized Reserves or National Guard. I am aware that I must have at least 6 months time-in-service left on my active duty contract at the time of surgery in order to be scheduled for surgery *(Army / Air Force / Space Force)* or 12 months time-in-service left for *(Navy / Marines / Coast Guard).*

Patient Signature: _____

MEDICAL INFORMATION

Are you allergic to medications? ☐Yes ☐No

List by name: _____

Have you had any immunizations in the last 12 months? ☐Yes ☐No

List by name & date given: _____

Please circle and list all medications you are currently taking: *(including over-the-counter medications and nutritional supplements)* Doxycline/Tetracyclines, Allergy Medications, Diabetic Medications, Thyroid Medications, Cordarone, Hormone Therapy, lmitrex, Coumadin, Retin-A/Accutane

Any others, please list: _____

Please describe:

Past Surgical History: _____

Major Illnesses: _____

Do you smoke? ☐ Yes(currently) ☐ No (never) ☐ No (Quit date: _____)

*******FEMALE PATIENTS ONLY*******

ARE YOU CURRENTLY OR IN THE PAST 6 MONTHS:

☐ Pregnant ☐ Nursing ☐ Miscarriage ☐Neither Pregnant, Nursing, or Miscarried in the last 6 months

Patient Signature: _____ *Date:*_____

Name *(Last, First, MI)*: _____ DOB: _____

FAMILY HISTORY

Do you have a family history of *(circle below)*:

Glaucoma	Macular Degeneration	Crossed or Lazy Eye	Cataracts
Corneal Disease	Retinitis Pigmentosa	Diabetes	Adopted
None of the above	Other: _____		

Have you ever been diagnosed and/or treated for:

Sleep Apnea	☐Yes	☐No
Diabetes *(year diagnosed)* _____	☐Yes	☐No
Heart Disease	☐Yes	☐No
Cancer *(type _____)*	☐Yes	☐No
Keloid Scarring	☐Yes	☐No
Herpes / Shingles / Cold Sores	☐Yes	☐No
High Blood Pressure / Hypertension	☐Yes	☐No
High Cholesterol	☐Yes	☐No
Arthritis	☐Yes	☐No
Lupus	☐Yes	☐No
Headache *(circle below)*	☐Yes	☐No
Migraine *Tension* *Sinus*		
Skin Ailments (circle below)	☐Yes	☐No
Eczema *Psoriasis* *Rosacea*		
Environment / Seasonal Allergies	☐Yes	☐No
Any problem(s) not listed?	☐Yes	☐No

Please specify: _____

Have you ever had:

Dry Eye	☐Yes	☐No
Glaucoma	☐Yes	☐No
Cataracts	☐Yes	☐No
Retinal Detachment	☐Yes	☐No
Eye Injury	☐Yes	☐No

Please specify: _____

Macular Degeneration	☐Yes	☐No
Iritis / Uveitis	☐Yes	☐No
Crossed Eye(s)	☐Yes	☐No
Lazy Eye / Amblyopia	☐Yes	☐No

Refractive Surgery *(circle one)*: LASIK PRK SMILE ICL

Date / Location: _____

Eye Surgery (other)	☐Yes	☐No

Please specify: _____

Eye Infections	☐Yes	☐No

Please specify: _____

Keratoconus	☐Yes	☐No

GLASSES / CONTACTS HISTORY

Do you now, or have you ever, worn glasses? ☐Yes ☐No How long? _____

Do you now, or have you ever, worn contact lenses? ☐Yes ☐No Date you last wore your contact lenses: _____

Hard contact lenses: _____ *(years)* Soft contact lenses: _____ *(years)*

Any problems while wearing contact lenses? (i.e. dry eye, lens intolerance, infections, red eyes, etc.) ☐Yes ☐No

Please specify: _____

Knowing that there can be **NO GUARANTEE** that glasses or contact lenses will no longer be necessary, what do you hope to achieve from refractive eye surgery?

_____

_____