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?

_____

_____

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR	**6. SOCIAL SECURITY NUMBER OR DOD IDENTIFICATION NUMBER OF MEMBER OR SPONSOR**	**7. DATE** *(YYYYMMDD)*