

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

|                         |                |
|-------------------------|----------------|
| <b>Office Use Only:</b> | 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) Doxycycline/Tetracyclines, Allergy Medications, Diabetic Medications, Thyroid Medications, Cordarone, Hormone Therapy, Imitrex, 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?

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