

WPAFB Warfighter Laser Surgery Center

Patient Information:

Full name: _____ Date: _____ Rank / Grade: _____

SSN: _____ DOB: _____ Age: _____ Sex: M / F

Status: AD / Active Reserve Service: USAF / USA / USN / USMC / Other _____ Job Title: _____

Date of separation/retirement/ID expiration: _____ Circle if applies: PRP / Aviation / Special Duty / NA
(Do not specify indefinite)

Home Location: Address: _____ City, State, Zip: _____ Phone (H): _____ (Cell): _____ E-mail: _____	Duty Location: Address: _____ City, State, Zip: _____ Phone (W): _____ E-mail: _____
--	--

Medical Information:

(DO NOT LEAVE ANY SPACES BLANK)

Drug Allergies / Sensitivities: _____

Current Medications: _____

Medical History: _____

Surgical History: _____

Please circle the following conditions that apply:

If none apply then place your initials here _____

Pregnant / Nursing/ Lactating	Autoimmune disease	immunodeficiency	Lupus	Dry eyes
Pacemaker / cardiac device	Thyroid disease	Acne Rosacea	Glaucoma	Cataracts
Rheumatoid Arthritis	Heavy scarring	Herpes Zoster (<i>shingles</i>)	Eye surgery	Keratoconus
Diabetes Mellitus	Corneal irregularity	Ocular Herpes Simplex	Atopic disease	Strabismus
Retinal problems	Refractive Surgery	Active ocular disease	Ocular allergies	Lazy eye
Multiple Sclerosis	Myasthenia Gravis	Crohn's Disease	Ulcerative Colitis	Grave's Disease
Behcet's Disease	Sjogren's Syndrome	Psoriasis	Guillain-Barre	Vitiligo

Please circle if you have ever used the following medications:

Imitrex (Sumatriptan) Accutane (Isotretinoin) Cordarone (Amiodarone) Steroids TB meds (INH) Immunosuppressive drugs
If yes, when last used: _____ If you have **not** used any of the above medications, place your initials here _____

Please answer the following:

(DO NOT LEAVE ANY SPACES BLANK)

Please list your hobbies or activities having special visual requirements (flying, swimming, golf, etc.)

Describe your expectations from refractive surgery (to see the clock in the morning, to see while swimming, etc.)

Are you wearing or have you worn contact lenses? Yes / No If yes: Date they were last worn? _____
What type of contacts? Soft / RGP / Hard / Unsure

(Soft contact lenses must not be worn 30 days prior to the pre-op exam. RGP (Rigid Gas Permeable) contacts must not be worn 90 days prior to the pre-op exam.) Place your initials here that you have read and understand this statement _____

Do you have a surgical preference? (circle one) PRK / LASIK / No Preference

Patient's Signature _____ Date: _____

Patient's Signature **(To be signed at Warfighter Laser Center Only)** _____ Date: _____