MADIGAN army MEDICAL CENTER
Refractive Surgery Clinic | (253) 968-5516

Patient Questionnaire

PATIENT INFORMATION

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

DOB: _____ Age: _____ DOD ID: _____ Last 4 SSN: _____ Gender: ☐ M ☐ F

Assigned at JBLM: ☐ Yes ☐ No Pending Disciplinary Action or Medical Evaluation Board (MEB): ☐ Yes ☐ No

Mailing Address: _____

Telephone Number: Work: _____ Cell: _____

Military Email (.mil): _____ Active Duty/AGR/Reserve (*circle one*)

Rank: _____ Branch of Service *(circle one)*: USA USAF USN USMC USCG USPHS

Unit of Assignment: _____ Occupational Specialty: _____

Are you being deployed? ☐ Yes ☐ No Date: _____ ETS Date: _____ PCS Date: _____

Training/TDY/Leave Dates: _____

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

I, (*print name*) _____, am a full-time active duty service member assigned to an active duty tenant unit at Joint Base Lewis-McChord. 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/AirForce*).

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, Imitrex, Coumadin, Retin-A/Accutan

Any others, please list: _____

Please describe:

Past Surgical History: _____

Major Illnesses: _____

Do you smoke? ☐ Yes CURRENTLY ☐ No NEVER ☐ No I 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
Iris/Uveitis ☐ Yes ☐ No
Crossed Eye(s) ☐ Yes ☐ No
Lazy Eye/Amblyopia ☐ Yes ☐ No
Eye Surgery (*circle one*): LASIK PRK N/A
Date/Location:
Eye Surgery (*other*) ☐ Yes ☐ No
Please specify:
Eye Infection ☐ Yes ☐ No
Please specify:
Keratoconus ☐ Yes ☐ No

GLASSES/CONTACT 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

Hard contact lenses: *years* Soft contact lenses: *years*

Date you last wore your contact lenses:

Any problems while wearing contact lenses? (*ie: 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 laser eye surgery?

Surgeon Signature: **Date:**