

WBAMC - WRESP PATIENT HISTORY QUESTIONNAIRE

Last name		First name		Please answer the following questions carefully and explain any "Yes" answers in the box below.				
Age	Date of Birth	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Duty Title or Occupation		ETS date						
Are you likely to Deploy, PCS, attend School or otherwise leave Ft. Bliss in the next 6 months?			<input type="checkbox"/> Yes <input type="checkbox"/> No					
Duty Status		<input type="checkbox"/> Active <input type="checkbox"/> Reserves <input type="checkbox"/> National Guard <input type="checkbox"/> Other <input type="checkbox"/> Active Guard Reserves						
Special Duty		<input type="checkbox"/> None <input type="checkbox"/> Ranger <input type="checkbox"/> Airborne <input type="checkbox"/> Air Assault <input type="checkbox"/> HALO <input type="checkbox"/> Aviation/Flight <input type="checkbox"/> SCUBA <input type="checkbox"/> Other <input type="checkbox"/> Special Operations						
List some of your hobbies and activities that require visual needs: (Example: computers, sports, etc.)			OCULAR HISTORY Do you or have you ever had the following?					
1. _____						Eye surgery or laser treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Eye injury or trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Told not candidate for Lasik/PRK <input type="checkbox"/> Yes <input type="checkbox"/> No Dry eyes <input type="checkbox"/> Yes <input type="checkbox"/> No Recurrent conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No Corneal ulcer/infection <input type="checkbox"/> Yes <input type="checkbox"/> No Corneal scar <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes eye infection <input type="checkbox"/> Yes <input type="checkbox"/> No Keratoconus <input type="checkbox"/> Yes <input type="checkbox"/> No Cataract <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma or high eye pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Retina problems <input type="checkbox"/> Yes <input type="checkbox"/> No Poor vision even with glasses <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. _____						Thyroid eye disease <input type="checkbox"/> Yes <input type="checkbox"/> No Iritis/uveitis <input type="checkbox"/> Yes <input type="checkbox"/> No Ocular rosacea <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic eye pain <input type="checkbox"/> Yes <input type="checkbox"/> No Glare/halos around lights <input type="checkbox"/> Yes <input type="checkbox"/> No Double vision <input type="checkbox"/> Yes <input type="checkbox"/> No Amblyopia or lazy eye <input type="checkbox"/> Yes <input type="checkbox"/> No Crossed eyes or eye misalignment <input type="checkbox"/> Yes <input type="checkbox"/> No Eye patching or eye exercises <input type="checkbox"/> Yes <input type="checkbox"/> No Problems wearing glasses, contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Reading glasses or glasses with bifocal or prism <input type="checkbox"/> Yes <input type="checkbox"/> No Any chronic eye problems or disease <input type="checkbox"/> Yes <input type="checkbox"/> No Family history of eye problems (excluding eyeglasses) <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. _____								
What do you hope to achieve from this surgery that will enhance your lifestyle and military job performance? (Example: "Field exercises without glasses getting dirty/broken") (Example: "Play sports without glasses falling off")			MEDICAL HISTORY Do you or have you ever had the following?					
1. _____						Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Breathing problems <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker or heart device <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Migraines or chronic headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Immunosuppression/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus or autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia-chronic pain syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No Poor wound healing <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia <input type="checkbox"/> Yes <input type="checkbox"/> No Immunizations in past 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No Skin problems: psoriasis or vitiligo <input type="checkbox"/> Yes <input type="checkbox"/> No Any chronic medical conditions (Females) Pregnant or nursing now or in the past 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. _____								
3. _____								
4. _____								
ALLERGIES								
Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Have you ever had a reaction to: percocet, codeine, or hydrocodone? <input type="checkbox"/> Yes <input type="checkbox"/> No								
MEDICATIONS								
Are you taking any of the following medications?								
Accutane (isotretinoin)		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Birth control pill		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Cordarone (amiodarone)		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Immunosuppressants		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Imitrex (sumatriptan)		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Steroid medication		<input type="checkbox"/> Yes <input type="checkbox"/> No						
Do you currently take any medications?			<input type="checkbox"/> Yes <input type="checkbox"/> No					

Explain any "Yes" answers from above:

Last Name	First Name	Rank/Grade	Today's Date
SSN	MILITARY email address		Your Primary phone number
UNIT		Duty Phone	MOS
Emergency Contact Person	Phone	Relationship	
How many years have you worn glasses?		How old are your current eyeglasses?	
How long have you worn contacts?		Last worn?	Brand <input type="checkbox"/> Soft <input type="checkbox"/> Rigid

I, _____ (Name) am requesting an evaluation for laser refractive eye surgery at William Beaumont Army Medical Center. By signing below I confirm that I have read and understand the following critical information concerning refractive eye surgery:

1. Certain medical or eye conditions may exist that can disqualify you from having surgery. You may be disqualified or you may withdraw from having surgery at anytime during the pre-operative process. Your doctor will make the final decision on whether you have surgery and what type of surgery (Lasik or PRK).
2. You must not have contact lenses in your eyes for **one month** prior to your pre-operative eye exam and surgery. Not complying may adversely impact the surgical result.
3. You must be available to see us for at least 3 months (but preferably 12 months) of post-operative care (no PCS, deployment, etc in that time frame). You will be required to return for all scheduled post-operative appointments.
4. To be considered for surgery, you must be at least 21 years old, have 18 months before ETS and be Active Duty assigned to an Active Duty unit and not Reserve or National Guard activated or otherwise.
5. You must bring the following to your pre-operative eye exam: current eyeglasses and any available prior eyeglass prescriptions.
6. (Females) You must not be pregnant or nursing 6 months before or after refractive eye surgery as it could adversely impact the surgical result.
7. You must have an escort/driver with you the day of surgery. You will be on con-leave and have a profile after the surgery as outlined on the Commander's Authorization Form.
8. You are not eligible for surgery if you have any adverse actions pending (ie: flag, chapter, medical board, UCMJ, etc).
9. If you are on special duty status now or in the future (ie: flight status, special forces, diver, etc) you must confirm with your unit surgeon that you are eligible for refractive eye surgery and see if any waivers or authorizations are required.
10. The Commander's Authorization Form must be signed and completed before consideration for surgery. The form expires 3 months after signature and if no surgery in that timeframe, will have to be resubmitted.
11. You may still need glasses or contacts after refractive eye surgery for your best vision.

(Signature) _____ (Date) _____

Contact Lenses _____
ERB/ORB (ETS) _____
Initials _____
CLINIC USE ONLY

COMMANDER'S AUTHORIZATION FOR REFRACTIVE EYE SURGERY WBAMC – FT BLISS

Refractive eye surgery is a laser treatment done to reduce dependence on eyeglasses and contact lens so active duty personnel are better able to function in their jobs and during training/deployment.

The following Soldier is requesting permission to be evaluated for surgery.

Rank	Name	SSN
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1. Requirements for the Soldier to be considered for surgery:
 - a. **18 months** remaining on active duty
 - b. Minimum of **3 months** remaining at Ft. Bliss after surgery without deployment or PCS
 - c. No adverse personnel actions pending

2. After surgery, the Soldier will be on **convalescent leave for 6 days** and will have a physical profile as follows:
 - a. For **one year** sunglasses must be worn outside during daylight hours
 - b. For **one month** may not do the following: No driving or riding in a tactical vehicle, no driving of military/government vehicles after sun down, no swimming, no wearing of pro-mask, no face paint, no organized PT. No contact sports. No combative training. No aerobic activity that generates perspiration as to avoid concentrated sweat entering the eyes. No NBC training to include gas chamber or riot control agents. No working in sunny, windy, dusty areas, and non-climate controlled areas. No non-climate controlled living environment (i.e. tents). No firing of any weapon system or exposure to live fire. Not to deploy/mobilize 90 days from date of surgery. No small pox vaccination.

3. Participation in the Warfighter Eye Surgery program requires some time investment resulting in absence from duty. The soldier **must** keep all scheduled appointments. Typical time requirements are as follows:
 - a. Initial eye exam – up to half a day
 - b. Surgery – 1 week off work
 - c. Post-operative exams – 5 visits scheduled during the first year

4. This authorization form is good for 90 days from the date it is signed. If surgery is not completed within that time, a new form will need to be submitted.

5. I understand the information above and hereby give my permission/endorsement for this soldier to be evaluated and considered for enrollment in the Warfighter Eye Surgery Program and to have laser eye surgery if eligible.

Commanders Name and Rank

Commanders Signature

WBAMC – Ft. Bliss
Refractive Eye Surgery Clinic
(915) 742-7051

Date

Phone number