MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
NAVHOSPBREMINST 6490.1	JUN 2019

LOCAL FORM TITLE *(Optional)*
REFRACTIVE SURGERY CLINIC - PRE-SCREENING

Updated On: _____ Staff Initial: _____

Personal Information **Any missing or incorrect information will delay your surgery.**

Today's Date (MM/DD/YYYY) _____

On the label below, is your identifying information correct?(Name, DoD, DOB) ☐ Yes - Please initial _____ ☐ No - List any corrections _____

Work E-mail _____ Phone: Home/Cell (____) ____-____ Work (____) ____-____ Ext ____

Supervisor Name And Number (If work # not available)_____ Phone (____) ____-____

Alternate Contact Name (Spouse, Roommate, etc) _____ Phone (____) ____-____

Current Street Address _____ City _____ State _____

Updated On: _____ Staff Initial: _____

Work Information

Branch of Service: ☐ Navy ☐ Army ☐ Marines ☐ Air Force ☐ Coast Guard ☐ Other _____

Time in Service (In yrs) _____Projected Rotation Date (MM/DD/YYYY) _____ End of Active Service Contract (MM/DD/YYYY) _____

Command _____ Department _____ Rank / Rate _____ / _____

Brief Description of Job Duties (layman terms) _____

Duty Status: ☐ Full Duty ☐ *Limited Duty ☐ *Light Duty *Approx time of completion Limited/Light _____

Are you scheduled for:

Deployments w/in 12 months ☐ No ☐ Yes - Approx. Date & Duration _____

TAD/Detachments/Underway w/in 3 months ☐ No ☐ Yes - Approx. Date & Duration _____

Leave w/in 3 months outside local area of your duty station ☐ No ☐ Yes - Approx. Date & Duration _____

General Information

Hobbies / activities (Boxing, MMA, computers, videogames, etc) _____

Do you sleep with a circulating fan? ☐ No ☐ Yes (Discontinued fan use is recommended after surgery)

Do you have any other current / pending consults / referrals / surgery? ☐ No ☐ Yes

If you answered "yes", please explain: _____

Do you have seasonal allergies? ☐ No ☐ Yes

If you answered "yes", please explain (season / geographic location / date medication was last used): _____

Do you have a refractive surgery preference? ☐ LASIK ☐ PRK ☐ SMILE (If no preference leave blank)

Updated On: _____ Staff Initial: _____

Medications

Drug / Latex Allergies ☐ Yes, list:_____ ☐ No Known Drug Allergies

Current Medications (Prescriptions/Over-the-Counter including supplements, gels, ointments, eye drops, and creams):

☐ No ☐ **Yes** * _____

Other medications taken within the last 30days: ☐ No ☐ **Yes*** _____

***If answered "yes"**, please list medical conditions that you are/were taking medications for _____

Updated On: _____ Staff Initial: _____

Optical History

How old are the pair of glasses you brought with you today _____ (Give approx time ie weeks/mo/yr)

Do you wear reading glasses/bifocals? ☐ No ☐ Yes

During the day, while awake, how often do you wear corrective lenses to see? (ie glasses or contacts) _____% of the day

Have you worn/tried on/been fitted for contact lenses? ☐ No ☐ Yes Type: ☐ Soft daily / monthly / biweekly ☐ Rigid Gas Permeable (hard lenses)

Date last worn: MM/DD/YYYY) _____

Have you ever slept in your contacts? ☐ No ☐ Yes

Approximate date you last slept in contacts: MM/DD/YYYY) _____

How often / long do you sleep in contacts? ☐ Couple times/year ☐ 1 week at a time ☐ 1 month or longer at a time ☐ Couple times/month ☐ 2 weeks at a time

PRACTITIONER'S NAME (Leave Blank)	PRACTITIONER'S SIGNATURE (Leave Blank)	DATE (Leave Blank)

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

HOSPITAL OR MEDICAL FACILITY	STATUS
DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN
RELATIONSHIP TO SPONSOR	

Updated On: _____ Staff Initial: _____

Medical History

Have you ever used:	No	Yes		No	Yes
Maxalt, Immitrex, Zomig	☐	☐	Accutane	☐	☐
Cordarone	☐	☐	Retin-A (Tretinoin, etc)	☐	☐
TB medication (INH, etc)	☐	☐			

If you answered "yes", please list the date medication was used last: _____

Mental health conditions, including those not managed by medications ☐ No ☐ Yes

If you answered "yes", please explain _____

Surgical History (List all surgeries, including wisdom teeth): ☐ No ☐ Yes

If you answered "yes", please explain _____

Do you have a history of fainting, dizziness, with medical procedures/blood draws or discussions regarding medical procedures? ☐ No ☐ Yes If you answered "yes", please explain _____

Do you ever rub your eyes? ☐ No ☐ Yes

If you answered "yes", please explain _____

Have you ever used / been evaluated for sleep apnea / CPAP / APAP? ☐ No ☐ Yes

If you answered "yes", please explain (diagnosis/test results and treatment plan) _____

Have you had any vaccinations within the last 2 months (flu, smallpox, etc)? ☐ No ☐ Yes - List type/date: _____

Do you have a history of cold sores, HSV I, or HSV II? ☐ No ☐ Yes - List type/date: _____

Do you use tobacco products? ☐ Quit - Date _____ (MM/DD/YYYY) ☐ Yes - Type & Frequency _____ ☐ Never

Have you been evaluated for / diagnosed with an autoimmune condition:

	No	Yes		No	Yes
Rheumatoid Arthritis	☐	☐	HLA B27	☐	☐
Lupus	☐	☐	Psoriasis	☐	☐
Multiple Sclerosis	☐	☐	HIV/AIDS	☐	☐
Sarcoidosis	☐	☐			
Sjogren's Syndrome	☐	☐	Other _____		

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Eye History

Have you been **evaluated for / diagnosed or treated for** any of the following?

	No	Yes		No	Yes
Recurrent iritis / uveitis	☐	☐	Dry Eye	☐	☐
Herpes infection in the eye	☐	☐	Amblyopia / "Lazy eye"	☐	☐
Corneal scarring	☐	☐	Eye/Eyelid-surgery	☐	☐
Glaucoma	☐	☐	PRK/LASIK/SMILE	☐	☐ (Even if evaluated and couldnt have procedure)

If you answered "yes" to any of the above, please explain _____

Do you have a family member with a history of eye disease (not including glasses and contacts)? ☐ No ☐ Yes If you answered "yes", please explain (family member and disease) _____

Flight Status Personnel ☐ N/A What is your position? ☐ Pilot ☐ Special Aircrew ☐ Air Traffic Control ☐ Flight Officer ☐ Enlisted Aircrew ☐ Other _____

Female Patients ONLY	No	Yes
Currently Pregnant	☐	☐
Pregnant within the last 3 months	☐	☐
Currently Breastfeeding	☐	☐
Breastfed in the last 3 months	☐	☐
Planning a pregnancy within 6 months	☐	☐
Taking Biotene supplements (false positive pregnancy test)	☐	☐

I verify that the above information is complete and accurate to the best of my knowledge.

Signature _____

Date _____

PRACTITIONER'S NAME (Leave Blank)	PRACTITIONER'S SIGNATURE (Leave Blank)	DATE (Leave Blank)

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

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