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)* NAVHOSPBREMINST 6490.1	ISSUANCE DATE 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)

Is your identifying information correct? (Name, DoD ID#, Date of Birth)
☐ Yes - Please initial ___________
☐ No - List any corrections ___________________________

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

Supervisor Name (If work # not available) ________________________ Phone (_____) _____-________

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

Current Street Address ________________________ City ______________ State _______

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Work Information

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

Time in Service (In yrs) ______________ Projected Rotation Date (MM / YYYY) End of Active Service (MM / YYYY)

Command ______________________ Department ______________________ Rank / Rate __________ / __________

Brief Description of Job Duties ____

Duty Status: ☐ Limited Duty ☐ Light Duty ☐ Full Duty

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 ☐ No preference

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Medications

Drug / Latex Allergies: ☐ No known drug allergies ☐ Yes, please explain ______________

Current Medications (Prescriptions/Over-the-Counter including supplements, gels, ointments, eye drops, and creams):
☐ No ☐ Yes ________________________

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

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Optical History

Glasses:

How old are the glasses you brought today? ____________ (wks/mos/yrs) How often do you wear your glasses? ____________ % of the day

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

Contact Lenses:

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	PRACTITIONER'S SIGNATURE	DATE
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	

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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: (MM / YYYY)

Medical/Mental Health Conditions (Including those managed by medication): ☐ 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? ☐ No ☐ Yes

If you answered "yes", please explain (Approximate date & cause(s)) ________________________________

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 / 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 with any of the following:

	No	Yes		No	Yes
Recurrent iritis / uveitis	☐	☐	Cataracts	☐	☐
Herpes infection in the eye	☐	☐	Amblyopia / "Lazy eye"	☐	☐
Corneal scarring	☐	☐	Dry eye	☐	☐
Glaucoma	☐	☐	Eye / Eyelid surgery	☐	☐

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 ________________

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