

**JBER REFRACTIVE SURGERY CENTER INFORMATIONAL SHEET**

Last, First, MI, Suffix (Jr., III): \_\_\_\_\_ Rank: \_\_\_\_\_  
SSN (FMP/xxx-xx-xxxx): \_\_\_\_\_ Age/DOB (annotate both): \_\_\_\_\_ Sex: \_\_\_\_\_  
Service: USAF USA USN/USMC USCG OTHER \_\_\_\_\_ Status: Active Duty Guard Reserve  
Occupation/AFSC/MOS (annotate both): \_\_\_\_\_ Flying Status: YES NO ASC: \_\_\_\_\_

""Date of Separation/Retirement: \_\_\_\_\_ A date is absolutely required. ""

'CURRENTLY ANTICIPATE OR UNDERGOING MEB: aaaaaaaaaaaaaa

**Contact Info:**

Address: \_\_\_\_\_ Unit: \_\_\_\_\_  
Phone(H): \_\_\_\_\_ Base: \_\_\_\_\_  
Phone(C): \_\_\_\_\_ Phone(W): \_\_\_\_\_  
Military Email: \_\_\_\_\_ Personal Email: \_\_\_\_\_  
Commander's Name: \_\_\_\_\_  
Commander's Email: \_\_\_\_\_

**Medical Information:** (please annotate completely. If nothing to annotate, please write "nothing")

Drug Allergies: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Medical History: \_\_\_\_\_  
Surgical History: \_\_\_\_\_

Do you now or have you ever had any of the following eye conditions?

Glaucoma YES NO Keratoconus YES NO Ocular allergies YES NO  
Dry eyes Cataract Strabismus/lazy eye  
Eye surgery Eye injury Corneal infection/scars  
Retinal problems Ocular Rosacea Ocular Herpes infection

Do you have any of these medical conditions?

Diabetes YES NO Psoriasis YES NO Immunosuppression YES NO  
Migraines Pacemaker Tuberculosis or positive PPD  
Acne rosacea Thyroid Disease

Do you have an autoimmune disease or have you been evaluated by a specialist for possible autoimmune disease?

Examples: Rheumatoid arthritis, Lupus, Multiple Sclerosis, Sarcoid, Sjogren's, Irritable Bowel Disease, HLA B27, psoriasis, vitilligo

Have you ever taken any of the following? YES NO If yes, mark box and indicate LAST DATE used in blanks.  
Steroids \_\_\_\_\_ Small pox vaccine \_\_\_\_\_ Accutane (Isotretinoin) \_\_\_\_\_  
TB meds (INH) \_\_\_\_\_ Immitex (sumatriptan) \_\_\_\_\_ Cordarone (Amiodarone) \_\_\_\_\_

Have you ever worn contact lenses? YES NO If yes, which type: Soft Hard Unsure  
How many years? \_\_\_\_\_ How many hours per day? \_\_\_\_\_ What date did you last wear? \_\_\_\_\_

\*\*Soft contact lenses *must not be worn 30 days prior to the preop exam or surgical date.* Rigid Gas Permeable contacts *must not be worn 90 days prior to the preop exam/surgical date.* Initial here that you have read and understand this statement \_\_\_\_\_\*\*

Females Only: Are you currently pregnant or planning to become pregnant in the next 6 months?  
Are you nursing or have you been nursing/pregnant in the last 6 months?

List your hobbies or activities having special visual requirements (Ex: flying, swimming, golf, shooting, sewing)

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

I, \_\_\_\_\_, AFFIRM THAT THE INFORMATION CONTAINED HEREIN IS TRUE, CORRECT, AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Preferred language:      English              Other: \_\_\_\_\_

What is your preferred method of learning?      Written      Visual      Other:  
(if other specify): \_\_\_\_\_

Do you have a learning disability, language barrier/hearing/vision deficit?      No      Yes  
(if yes specify): \_\_\_\_\_

Do you have an advance directive completed?      Yes      No

Is a copy of the advance directive in your record?      Yes      No

Do you have any cultural or religious beliefs that may affect your care?      No      Yes  
(if yes specify): \_\_\_\_\_

***I understand that by committing to the refractive surgery program I will adhere to the post-op mandatory 1week, 1, 3, 6 & 12 month follow-up visits, even if I PCS after treatment is provided. These are WRESCu directed and not a choice. Failure to comply with follow up appointments or persistent no-shows will result in notification to my leadership.***

Signature \_\_\_\_\_