

**MADIGAN HEALTHCARE SYSTEM  
REFRACTIVE SURGERY CENTER PATIENT QUESTIONNAIRE**

PATIENT INFORMATION

Date: \_\_\_\_\_ Name (Last, First, MI): \_\_\_\_\_

SSN: \_\_\_\_\_ DOD ID: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ M F

Rank: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Telephone Number (s): Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Full AKO Email: \_\_\_\_\_

Unit of Assignment (CO/BN/BDE): \_\_\_\_\_

Are you BEING deployed to Iraq, Afghanistan or any other location? No Yes Date: \_\_\_\_\_

ETS Date: \_\_\_\_\_ PCS Date: \_\_\_\_\_ TDY/Leave Dates: \_\_\_\_\_

**I, (print name) \_\_\_\_\_, am a full- time active duty Soldier assigned to an active duty tenant unit at Joint Base Lewis-McChord. I am NOT on active duty orders as a mobilized Reserve or National Guard Soldier. I am aware that I must have at least 18 months time-in-service left on my Active Duty contract at the time of surgery to be scheduled for surgery.**

**Patient Signature:** \_\_\_\_\_

MEDICAL INFORMATION

Are you allergic to any medications?  Yes  No

If yes, please list medications by name: \_\_\_\_\_

Have you had any immunizations in the last 12 months?  Yes  No

If yes, please list them: \_\_\_\_\_

Please circle and list all medications you are currently taking (include over-the-counter medications and nutritional supplements):

Doxycycline/ tetracycline's      Allergy medications      Diabetic medications      Thyroid medications  
Accutane      Cordarone      Hormone Replacement Therapy      Imitrex      Coumadin

Any others, please specify: \_\_\_\_\_

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 have you had/been in the last 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 (*please circle below*):

Glaucoma	Diabetes	Macular Degeneration	Crossed or Lazy Eye
Cancer	Corneal Disease	High Blood Pressure	Retinitis Pigmentosa
Cataracts	Adopted	Other: _____	None of the above

Have you ever been diagnosed and/or treated for:

Have you ever had?

	Yes	No
Diabetes (year diagnosed _____)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
Keloid Scarring	<input type="checkbox"/>	<input type="checkbox"/>
Herpes/Shingles/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure (Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid (circle below)	<input type="checkbox"/>	<input type="checkbox"/>
Low   High   Graves		
Headache (circle below)	<input type="checkbox"/>	<input type="checkbox"/>
Migraine   Tension   Sinus		
Skin Ailments (circle below)	<input type="checkbox"/>	<input type="checkbox"/>
Eczema   Psoriasis   Rosacea		
Other autoimmune disease not listed	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
please specify _____		
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Iritis/Uveitis	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eye(s)	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye/Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
please specify _____		
Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>
please specify _____		
Any eye problem(s) not specified above?		
please specify _____		

Any medical problem not specified above?  
Please specify \_\_\_\_\_

**GLASSES/CONTACT HISTORY**

Do you now, or have you ever, worn glasses?      Yes    No    If yes, how long? \_\_\_\_\_

Do you now, or have you ever worn contact lenses?      Yes    No    If yes, see below:

Hard contact lenses: \_\_\_\_\_ years     Soft contact lenses: \_\_\_\_\_ years

Date you REMOVED your contact lenses: \_\_\_\_\_ (must have them out 2 weeks for every 10 years for soft contact lenses, or 4 weeks for every 10 years for hard contact lenses)

Any problems while wearing your contact lenses? (ie: dry eye, lens intolerance, infections, red eyes, etc)

Yes     No If yes, 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 having laser eye surgery? \_\_\_\_\_

(Refractive)

**SURGEON SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_