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| MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA For use of this form, see AR 40-66; the proponent agency in the Office of the Surgeon General. | | | | | | |
| REPORT TITLE LRMC REFRACTIVE SURGERY PATIENT INFORMATION FORM (PAGE 1) | | | | | | OTSG APPROVED |
| LAST NAME | | | | OCCUPATION | AFSC/MOS | |
| FIRST NAME MI: | | | | PERSONAL MILITARY ADDRESS | | |
| SOCIAL SECURITY NUMBER | | | |
| RANK | GENDER  M F | | DEROS | APO | ZIP | |
| STATUS  ACTIVE DUTY  RESERVE  RETIREE  DEPENDENT  OTHER | | SERVICE  USA  USAF  USN  USMC  OTHER | | DUTY PHONE  DSN:  COMMERCIAL: | | |
| DUTY E-MAIL | | |
| CIVILIAN STREET ADDRESS | | | | EMERGENCY CONTACT | | |
| HOME PHONE | | | | RELATIONSHIP | | |
| HOME E-MAIL | | | | PHONE | | |
| YOUR INTERESTS (CIRCLE AS APPROPRIATE):  AEROBICS JOGGING OTHER (SPECIFY)  BIKING HIKING FAMILY  MOVIES READING SHOPPING | | | | AMOUNT OF TIME YOU SPEND WEARING GLASSES OR CONTACT LENSES FOR *DISTANCE* VISION (CIRCLE ONE)  0% <25% 26-50% 51-75% 75-100% | | |
| HOW MANY YEARS HAVE YOU WORN GLASSES? | | | | HOW OLD IS YOUR CURRENT GLASSES PRESCRIPTION? | | |
| DO YOU OR HAVE YOU EVER WORN BIFOCALS? | | | | HOW MANY YEARS HAVE YOU WORN CONTACT LENSES? | | |
| WHEN DID YOU LAST WEAR CONTACT LENSES? | | | | HAVE YOU EVER HAD DIFFICULTY WITH CONTACT LENS WEAR?  (DESCRIBE) | | |

**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?**

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*(Continue on reverse)*

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| PREPARED BY (*Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | | DATE |
| PATIENT’S IDENTIFICATION *(For typed or written entries, give: Name- last,*  *First, middle; grade; date; hospital or medical facility)* | | HISTORY/PHYSICAL FLOW CHART  OTHER EXAMINATION OTHER *(Specify)*  OR EVALUATION  DIAGNOSTIC STUDIES  TREATMENT | |

DA FORM 4700, MAY 78 MCEUL OP 478, 27 Mar 02 USAPPC V2.00

Ad Hoc apprvl - 26 Mar 02