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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 TITLELRMC 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 |
| STATUSACTIVE DUTYRESERVERETIREEDEPENDENTOTHER | SERVICEUSAUSAFUSNUSMCOTHER | 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 FAMILYMOVIES 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