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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 2)  | OTSG APPROVED  |
| DO YOU OR HAVE YOU EVER HAD THE FOLLOWING ?(CIRCLE AS APPROPRIATE)AMBLYOPIA/LAZY EYECATARACTSRECURRENT CONJUNCTIVITISCORNEAL ULCERDOUBLE VISIONDRY EYESGLAUCOMA OR HIGH EYE PRESSUREHERPES SIMPLEX/ZOSTERKERATOCONUSRETINAL PROBLEMSEYE INJURYOTHER: (SPECIFY) | DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? (LIST MEDICATION AND REACTIONS) |
| HAVE YOU EVER HAD SURGERY OR LASER TREATMENTS ON YOUR EYES? (SPECIFY) |
| ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE AS APPROPRIATE)ACCUTANE (ISOTRETINOIN)CORDARONE (AMIODARONE)IMMUNOSUPPRESSANTSIMITREX (SUMATRIPTAN)STEROIDSLIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING: |
| MEDICAL HISTORYDO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE AS APPROPRIATE)ARTHRITISBREATHING PROBLEMSDIABETESHEART DISEASE OR PACEMAKERHIGH BLOOD PRESSUREIMMUNOSUPPRESSION/HIVMIGRAINE HEADACHESOTHER MEDICAL PROBLEMS (SPECIFY) | PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
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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