Refractive Surgery Center

Naval Medical Center San Diego

Personal / Occupational Information

Last Name: ____________________ First: ____________ M.I.: ______

Last 4 of SSN: __________ DOB: ______________ ☐ Male ☐ Female

Rank/Rate: __________ Service: ____________ Time in Service: __________

Rotation Date: ____________ End of Service: ____________ Race: ______________

Command: ____________________ Job Description: ____________________

Current Flight Status / Receive Flight Pay? Y ☐ N ☐ Next scheduled deployment: ________

Home Address: ____________________ City: ____________ State: ______ Zip: ________

Cell/Home Phone: ____________________ Work Phone: ____________________

Work Email: ____________________ Personal Email: ____________________

IMPORTANT: We need an alternate, reliable contact that we can use to reach you.

Name: ____________________ Relation: ____________________

Phone Number: ____________________ Email: ____________________

Medical / Ocular History

Current Medications: ________________ Drug Allergies: ____________________

Medical/Surgical History: ____
(List significant conditions other than routine illness)

Y	N	Do you have or have you ever had…	Y	N	
☐	☐	Problems with dry eyes?	☐	☐	Are you HIV positive?
☐	☐	Herpes infection in either eye?	☐	☐	Are you currently, or have you been in the last 6-months, pregnant or breast feeding?
☐	☐	Any previous eye/eyelid surgery?	☐	☐	Do you wear lash extensions?
☐	☐	Thyroid problems?	☐	☐	Are you on Limited Duty?
☐	☐	Diabetes?	☐	☐	Are you being evaluated by a Medical Board?
☐	☐	Arthritis?	☐	☐	Do you have any serious or chronic medical conditions not previously listed? (Please list)
☐	☐	Chronic skin rash?			____________________

Patient Signature* ______________________________ Date ______________

**Signing this document states that all information is current and accurate.*