SCREENING QUESTIONAIRE

Patient Name (Last, First, M.I): _____ **Rank:** _____

SS# (Last 4):_____

List your hobbies or activities that require special visual needs (Example: skiing, woodworking, computers, sports, etc.):

_____

In your own words, please list what your expectations from eye surgery are:

_____

How long have you worn glasses? _____ **Years, since age** _____

Do you wear Contact Lenses N/A If yes, for how long? _____ Years_____Months_____Hours per day
Last day worn _____

What Type of Contact Lenses? N/A Rigid gas perm N/A Soft

N/A Daily N/A Extended N/A Disposable N/A Occasional

Do you have, or have you ever had any of the following eye conditions:

N/A	Corneal Diseases	N/A	Keratoconus	N/A	Glaucoma
N/A	Herpes Keratitis	N/A	Elevated eye pressure	N/A	Amblyopia / Lazy eye
N/A	Eye Surgery / Laser	N/A	Cataract	N/A	Retinal Problems
N/A	Prism in eyeglasses				

Other eye problem or dates of eye surgery:

_____

Family History: N/A Keratoconus N/A Glaucoma

Other eye problems: _____

Do you have or have you been treated for the following medical problems?

N/A Connective tissue disease, autoimmune disease, immuno-deficiency (e.g. Rheumatoid Arthritis, Lupus, Sarcoid, HIV)?

N/A Diabetes? If so, for how long and what type? _____

N/A Smallpox vaccination in the last 3 months? If yes include the date._____

N/A Formed keloids? (E.g. heavy scarring over cuts, stitches or surgical incisions)?

N/A Taking any of these medications?
Accutane (isoretinoin) for acne, or Cordarone (amiodarone hydrochloride) for controlling irregular heartbeat, or Imitrex (sumatriptan) for migraine headaches?

N/A For female, have you been pregnant or nursing within the last 3 months?

Other health problems:

_____

List all medications you take regularly including over-the-counter medications and vitamins:

_____

_____

Are you allergic to any medications? (Please list and include any shellfish, iodine, and latex allergy):

_____

_____

Laser vision correction questions:

I understand that laser vision correction may not correct all of my myopia, hyperopia, and or astigmatism and that I may still need to wear glasses or contact lenses after laser surgery for the best correction of my vision.
_____ (patient initials)

I understand there is a chance I cannot be fit with contact lenses after laser vision correction.
_____ (patient initials)

I understand that reading glasses may be needed after laser vision correction, even if not needed now.
____ (patient initials)

Any recent hospitalizations or overnight stays at the hospital? N/A If yes, for how long? _____

Is your spouse (or someone who lives with you) a healthcare worker? N/A If yes, for how long? _____

Please SELECT the response that best describes your current symptoms. (Before Surgery)

Pre-op Symptoms	Right Eye		Left Eye	
Dry Eyes	0	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe	4	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe
Glare / Haloes	4	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe	4	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe
Quality of daytime vision with current lenses	4	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor	4	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor
Quality of nighttime vision with current lenses	4	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor	4	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor
Overall satisfaction with your current lenses	4	0 = very satisfied 1 = somewhat satisfied 2 = satisfied 3 = mildly dissatisfied 4 = very dissatisfied	4	0 = very satisfied 1 = somewhat satisfied 2 = satisfied 3 = mildly dissatisfied 4 = very dissatisfied

Patient statement: "I certify that the above information is complete and correct to the best of my knowledge and that I have reviewed the Cadet Refractive Eye Surgery Program PDF"

Patient Signature: _____

Physician Signature_____

WEST POINT REFRACTIVE SURGERY PROGRAM

ADMINISTRATIVE DATA

Patient Name:_____ **Rank:**_____ **SS#:**_____

Branch of Service:_____ **Unit/Company:**_____ **Occupation (MOS):**_____

Are you an aviator / on flight status or receive flight pay?_____

DOB:_____ **Age:**_____ **Sex: M / F**

What is your eye color? (circle one) Blue Brown Hazel Other: _____

Phone Numbers: Home: _____ **Work:**_____ **Fax:** _____

Email Address: _____

AKO Email Address: _____

Mailing Address: _____

RELEASE OF INFORMATION

I, the undersigned, give permission for my name/e-mail address to be included in group e-mails for the sole purpose of transmitting information or instructions as pertains to my participation in the Cadet Refractive Eye Surgery Program (CRESP).

_____
SIGNATURE

_____
PRINTED NAME

TAC Officer ENDORSEMENT for REFRACTIVE SURGERY

Cadet Refractive Eye Surgery Program
Phone 845-938-2207

MEMO for: Chief, Ophthalmology, KACH

SUBJECT: Tactical Officer's Endorsement of Refractive Eye Surgery

CADET:

Name *SSN*

1. This cadet is interested in corneal refractive eye surgery to reduce his/her need for corrective lenses.
2. This cadet completed his/her first two years at the USMA & signed an active-duty obligation to the US Army or has 18 months left on a prior service active duty obligation.
3. This cadet is in good standing academically, militarily & physically:
   a. No honor investigations pending.
   b. No medical boards pending.
   c. No academic boards pending.
   d. No disciplinary probation.
   e. No physical fitness probation.
4. After refractive surgery this cadet will receive a temporary profile:
   a. Quarters for 1-4 days.
   b. No written exams for one week.
   c. No organized IOCT/APFT for one month (PT at own pace & distance).
   d. No contact sports, boxing or combatives for one month.
   e. No field duty, night operations or jumping for one month.
   f. No wearing of protective NBC mask or face paint for one month.
   g. No swimming, diving, firing weapons or driving military vehicles for one month.
   h. Sunglasses MUST be worn outdoors & in bright lights for 3 months.
   i. No deployments for 3 months after PRK or one month after LASIK.

   NOTE: Sometimes these restrictions must be prolonged, depending on healing & recovery.

5. This cadet will make all follow-up appointments to ensure proper healing. Appointments are usually scheduled one day, one week, one month, 3 months, 6 months & 12 months after surgery.
6. Please notify us immediately if the cadet's circumstances change & he/she no longer meets the above criteria.
7. This endorsement is valid for 1 semester. If surgery cannot be performed within that semester, a new endorsement must be completed.
8. By signing below, I agree to comply with all the above statements.

TAC Officer Signature Block

Name, Rank & Signature

Phone #

E-mail Address

Date of Signature

*This document may only be signed by an OFFICER in the cadet's tactical chain of command, (NCO signature is not accepted)

West Point Refractive Eye Surgery Program
Commander's Authorization
(TO BE SUBMITTED BY ALL ACTIVE DUTY APPLICANTS)

(1) I give my permission for the following active duty soldier to be considered for enrollment in the Warfighter Refractive Eye Surgery Program (WRESP) and for treatment if eligible.

Patient Name (Print) (Last / First / MI) Rank SSN

Email Address (AKO Preferred)

(2) I certify the following to be true:

The soldier has at least 6 months remaining on **ACTIVE DUTY**.
The soldier has no adverse personnel actions pending including medical boards.
The soldier will remain **CONUS** and is **NON-DEPLOYABLE** for at least **90 DAYS** post-surgery.

(3) I realize that after refractive surgery the soldier will be on **CONVALESCENT LEAVE** up to **96 HOURS** and will have the following **PHYSICAL PROFILE** for a minimum of **30 DAYS**, but possibly up to 90 days in a small number of patients (<10%):

No parachuting, diving, night operations or driving military vehicles.
No field, range or other duties involving strenuous activity including AFPT.
No swimming, protective mask use, or use of camouflage face paint.
SM will not carry or fire a weapon within 30 days after treatment.
Needs to wear sun-glasses at all times.

(4) I acknowledge that **NATIONAL GUARD** and **RESERVE** soldiers are **NOT** eligible for treatment .

(5) I acknowledge this soldier is required to complete 1, 3, 6 and 12-month **FOLLOW-UP EXAMS** required by the Refractive Eye Surgery Program. Or if deploying before the 6-month exam is due they are required to complete the 1- and 3-month exams and then return to KACH or co-managing optometry clinic for a post-operative exam at the completion of their deployment.

(6) Failure to comply with the post-operative care requirements may affect future enrolments from the soldier's unit.

Commander's Signature Commander's Rank and Name (Print) Date

Commander's Email Address Commander's Telephone Number

Applicant's Signature Date

KEEP A COPY FOR YOUR RECORDS AND BRING IT TO YOUR FIRST APPOINTMENT