MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE IACH WRESP PATIENT HISTORY QUESTIONAIRE	OTSG APPROVED *(Date)* *(YYYYMMDD)*

OCULAR HISTORY

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

Amblyopia / lazy eye	YES	NO
Cataracts	YES	NO
Glaucoma	YES	NO
Conjunctivitis (recurrent)	YES	NO
Corneal ulcer	YES	NO
Double vision	YES	NO
Dry eyes	YES	NO
Herpes simplex / zoster	YES	NO
High eye pressure	YES	NO
Keratoconus	YES	NO
Retinal conditions	YES	NO
Trauma / other (please list below)	YES	NO

_____

MEDICAL HISTORY

Do you have, or have you had, any of the following health conditions?

Arthritis	YES	NO
Breathing difficulty	YES	NO
Diabetes	YES	NO
Heart conditions	YES	NO
High blood pressure	YES	NO
Migraine headaches	YES	NO
Pacemaker	YES	NO
Immunosuppression / HIV	YES	NO
Other medical conditions (please list below)	YES	NO

_____

Females:

In the last 6 months, have you been pregnant or breastfeeding? YES NO

Contact Lens wear?_____Last worn?_____

ALLERGIES

Do you have any allergies to medications? YES NO
If so, list medications and reactions:

_____

OCULAR SURGERY

Have you ever had surgery on your eyes? YES NO
If so, specify the type of surgery and eye(s).

_____

MEDICATIONS

Are you taking, or have you taken, any of the following medications? If so, specify the date last taken:

Accutane (isotretinoin)	YES (Date:_____)	NO	Imitrex (sumatriptan)	YES (Date:_____)	NO
Birth control pill	YES (Date:_____)	NO	Immunosuppresant	YES (Date:_____)	NO
Cordarone (amiodarone)	YES (Date:_____)	NO	Steroids	YES (Date:_____)	NO

List any other medications your are currently taking (or write NONE): _____

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*

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 OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

_____