USMEPCOM Refractive Eye Surgery Worksheet

(For use of this form, see USMEPCOM Reg 40-1)

Please provide the following information about your patient's refractive eye surgery. Please include auto or manifest refractions that you have performed, and do not include visual acuity measurements.

Patient's Name: _____ DOB: _____

Date of refractive surgery: OD: _____ OS: _____

Type of refractive surgery: OD: _____ OS: _____

Date of pre-operative ☐ auto or ☐ manifest refraction: _____

OD: Sphere _____ Cylinder: _____ Axis: _____

OS: Sphere _____ Cylinder: _____ Axis: _____

Date of post-operative ☐ auto or ☐ manifest refraction #1: _____

OD: Sphere _____ Cylinder:_____ Axis: _____

OS: Sphere_____ Cylinder: _____ Axis: _____

Date of post-operative ☐ auto or ☐ manifest refraction #2: _____

(*Must be at least 30 days after post-op refraction #1, and may be performed at the MEPS by auto refraction*)

OD: Sphere_____ Cylinder:_____ Axis: _____

OS: Sphere_____ Cylinder:_____ Axis: _____

Any post-op complications? Yes ☐ No ☐

Any eye medications prescribed in the past three months? Yes☐ No ☐

If yes to either above, please explain:

Provider's Name: _____ Signature: _____ Date: _____

Office Address: _____ Office Phone: _____

Privacy Act Statement
Authority: Sections 505, 508, 510, and 3012 of Title 10 U.S. Code and Executive Order 9397. Principal Purpose: Information collected will be used to assist in the military qualification process. Routine Uses: Blanket routine use disclosures as described in USMEPCOM REG 40-1. Disclosure: Voluntary