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: ______________

(*Must be at least 90 days post-op*)

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 two months? Yes ☐ No ☐

If yes to either above, please explain:

Provider's Name: ______________________ Signature: ______________________ Date: ______________

Office Address: ______________________ Office Phone: ______________________

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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