MFS Personal Data Form

Date Scheduled:

Last Name, First Name, FULL Middle Name:	SSN:	Sex: ☐ Male ☐ Female
DoD ID NUMBER	☐ AFROTC CADET ☐ RESERVE ☐ GUARD ☐ ACTIVE DUTY	
Home of Record (Address)	Emergency contact: (Name, Relation, Address, and Phone Number)	
Current Address	Date of Birth Day: Month: Year:	Place of Birth
Home Phone (include area code)	☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Pacific Islander/Hawaiian	
Cell Phone (include area code)	Duty Phone: DSN:	Email Address:
ACTIVE DUTY, GUARD, AND RESERVE How long have you been in the military? Years: Months: Rank: Major Command: Base: Squadron and Unit:	**AFROTC CADETS** Det #: College: Det NCO & Phone #:	Preferred Hand: ☐ Right ☐ Left **Please specify duty you are applying for:** ☐ Pilot ☐ Flight Surgeon ☐ GBO/RPA Pilot

1	**Have you had corneal refractive surgery (CRS) (IF YES, CLICK LINK FOR WORKSHEET)? Example: PRK, LASEK, or LASIK eye surgery** ☐ No ► Continue to next question ☐ Yes ► You must send all pre & post-surgery reports and 6 mo eval along with the surgical LASER REPORT.		
2	**A) Do you have a family history of diabetes? If so, please specify relation of family member.** ☐ Yes ☐ No	**B) Were you born premature, prior to 37 weeks? If so, please specify gestational age.** ☐ Yes ☐ No	**C) Did you ever have "childhood" asthma?** ☐ Yes ☐ No Have you ever been prescribed and/or used an inhaler, nebulizer or medications to assist you with breathing? ☐ Yes ☐ No
3	**Complete Medical History Pre-Exam, CAC login required -** https://pepp.cce.af.mil/pepp/login/login.cfm **Select:** Start a Medical History Pre-Exam - User Key **Non-CAC holders:** Have your Recruiter or Detachment NCO login. The Medical History Pre-Exam will not be associated with the CAC Card.		
4	**Have you ever been seen or treated for Depression, Anxiety, ADHD, or Adjustment Disorder?** ☐ Yes ☐ No ► **If yes, please explain with diagnosis, dates, and medication(s) used/last used.**		
5	**Do you have a DOD/Military ID card?** ☐ Yes ☐ No ► Please provide Driver's License information below		

Driver's License State:	Driver's License #:

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If you have or ever had (birth to present) any of the medical conditions listed below, we will require more information. **Please circle any of the conditions below that apply to you to avoid any examination delays.**

ADD or ADHD

Motion sickness

Sleepwalking

Bedwetting

Kidney stones

History of asthma

Used an inhaler

Head injury or loss of consciousness

Headaches or Migraine Headaches

Allergies

Corneal Refractive Surgery (PRK, LASIK, or LASEK)

Abnormal PAP Smear (Women only)

Ophthalmology Questionnaire

Please check YES or NO to the following questions and explain in the space provided.

	YES	NO
1. Have you ever had any type of eye surgery to include: refractive eye surgery (PRK or LASIK), eye muscle surgery, eye lid surgery, cataract surgery, etc.?	☐	☐
If yes, please list type and when:		
2. Have you ever been diagnosed with lazy eye or amblyopia? Did you have to wear an eye patch as a child or glasses in childhood?	☐	☐
If yes, please list when:		
3. Have you ever had any trauma to or around your eye? Have you ever broken a bone in your facial area?	☐	☐
If yes, list where and when:		
4. Have you ever worn contact lenses to include soft and hard contacts, or the one's you sleep in at night and take them out in the morning? **(Soft contact lenses must be removed for 30 days and hard contacts must be removed for 90 days prior to date of appointment or your Flying physical will not be completed and will be deferred)**	☐	☐
If yes, please indicate what type and list the last time you wore them, even for an hour:		
5. Have you ever failed depth perception or had any known issues with depth perception?	☐	☐
If yes, please explain:		
6. Have you ever failed color vision or had any known issues with color vision?	☐	☐
If yes, please explain:		

Privacy Act-1974 as Amended applies. This form contains information which must be protected IAW DoD 5400.11 and it is Official Use Only (FOUO). In addition, this transmission may contain information covered under the Privacy Act, 5 USC 552(a), Health Insurance Portability and Accountability Act Public Law 104-191, and DoD Directive 6025.18, DoD Health Information Privacy Regulation. It must be protected in accordance with those provisions.

Tattoo/Branding Screening

(For use of this form see USAREC Reg 601-210)

PRIVACY ACT STATEMENT

AUTHORITY: Collection of this information is authorized by 10 USC, sections 503, 505, 532, 12101 and Executive Order 9397.

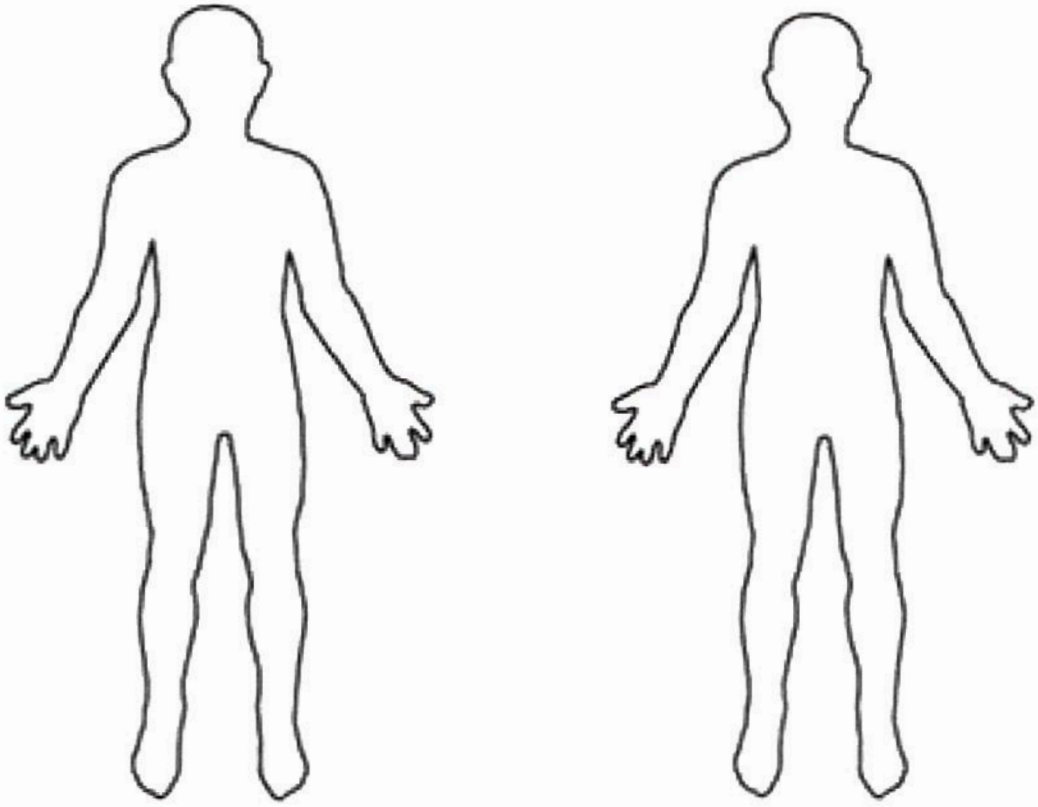
PRINCIPAL PURPOSE: Information collected will be used to assist in the prequalification process.

ROUTINE USES: Blanket routine use disclosures as described in AR 340-21, paragraph 3-2.

DISCLOSURE: Voluntary; however, failure to provide the information may delay or terminate the enlistment process.

Mark tattoo/brand on the body with a number.

FRONT **BACK**



Describe tattoo/branding below by corresponding number marked on the body. Indicate meaning next to corresponding number for all tattoos and brands only.

(Example) Tattoo: Heart with name	Meaning: Daughter's name - she is my heart
(Example) Right shoulder brand: Heart with arrow through it.	Meaning: Broken heart
1.	
2.	
3.	
4.	
5.	

Continuation page:

Describe tattoo/brands below by corresponding number marked on the body. Indicate meaning next to corresponding number for all tattoos and brands.

6.	
7.	
8. Updated 05 Feb 2025	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

Additional Information/Comments:

CORNEAL REFRACTIVE SURGERY (CRS) CHECKLIST

Must Be Completed By Your Eye Care Professional

NAME:	LAST 4 SSAN	Scheduled Date of AF Physical Exam:

Notes for Eye Care Professional: This patient is applying for a United States Air Force medical clearance which has very specific requirements. The purpose of this form is two-fold: to document the individual's pre-operative cycloplegic refraction so that Air Force medical personnel can verify pre-operative suitability for specific duties AND to document post-operative refractive error at the times indicated below to determine post-operative suitability for specific duties. Your assistance in treating/assessing this patient and providing this documentation is greatly appreciated.

Applicants must be at least **6 months post-CRS** prior to an accession medical examination or initial flight physical (**one year** for **hyperopic** CRS treatments prior to initial flight physical).

Approved CRS procedures include: photorefractive keratectomy (PRK), epithelial-laser in-situ keratomileusis (epi-LASIK), laser in-situ epithelial keratomileusis (LASEK), and laser in-situ keratomileusis (LASIK) with flap formation either by microkeratome or femtosecond laser (Intralase). Although it is expected that most, if not all, procedures will be accomplished using wavefront-guided technique, this is not a requirement.

Non-Approved CRS procedures include radial keratotomy, limbal relaxation incisions, thermokeratoplasty, intra-corneal rings, clear lens extraction and any phakic lens implantation. These procedures are **disqualifying and NOT waiverable** for ALL flying positions without exception.

The current use of punctual plugs is **disqualifying** for an initial physical. If you had punctual plugs inserted pre or post operatively, they **must be removed at least 30 days prior** to your evaluation. Failure to do so will **delay the processing** of your physical.

General Military Service or Commissioning:

Pre-Operative cycloplegic refraction **cannot exceed a spherical equivalent of +8.00 to -8.00** and **cannot exceed 3.00 diopters of astigmatism** with a good outcome to be **non-disqualifying** for accession.

Initial Flying Class (IFC I/IA/II/III/RPA Pilot) or Special Operational Duty:

Pre-Operative cycloplegic refraction **cannot exceed +3.00 to -8.00 in ANY meridian** and **cannot exceed 3.00 diopters of astigmatism** with a good outcome to be **non-disqualifying** for all flying classes.

Pre-Operative cycloplegic refraction **greater than +3.00 and less than or equal to +5.00** or **greater than -8.00 and less than or equal to -10.00** in **ANY meridian** or **greater than 3.00 and less than or equal to 6.00 diopters of astigmatism** is **DISQUALIFYING** for all flying classes and **may** be considered for a waiver on a **case-by-case basis.** Astigmatism greater than 5.00 diopters will **not** be waived for accession/commissioning.

1. PRE-OPERATIVE exam with cycloplegic refraction:

Date: _____

OD: Sph: _____ Cyl: _____ Axis: _____ 20/

OS: Sph: _____ Cyl: _____ Axis: _____ 20/

2. OPERATIVE REPORTS, must provide copy of LASER REPORT: Surgery Date:_____

3. Two post-op manifest refractions with no more than 0.50 diopter shift in sphere or cylinder power (initial post-op refraction must be at least 90 days post-CRS and second refraction at least 1 month apart) WE WILL NOT ACCEPT AUTO-REFRACTIONS AS A MANIFEST REFRACTION:

Date : _____

OD: Sph: _____ Cyl: _____ Axis: _____ BCVA 20/
OS: Sph: _____ Cyl: _____ Axis: _____ BCVA 20/

Date: _____

OD: Sph: _____ Cyl: _____ Axis: _____ BCVA 20/
OS: Sph: Cyl: Axis: BCVA 20/

List any surgical or post-operative complications (e.g. corneal haze, flap striae, ocular hypertension, etc.):

List any current eye medications used (including over-the-counter) and frequency of use:

List any side effects secondary to the surgery.

	YES	NO		YES	NO
Glare/ghosting/halos	☐	☐	Double Vision:	☐	☐
Dry Eye:	☐	☐	Difficulty seeing at night:	☐	☐

Please explain all YES responses:

Notes:

- **Send us ALL of your pre & post-operative exams (as well as any other eye surgeries) with this sheet.** Please DO NOT FORGET to ask for the actual "*LASER REPORT*", this item must be sent to us.
- The laser report is the actual form printed from the machine/laser (NOT THE TREATMENT PLAN) that was use to complete your surgery--without this form, your IFC physical may be canceled or delayed.

This sheet and accompanying documents must be submitted at least 30 days prior to your appointment.

_____ _____

Printed name & stamp (Eye care professional) Signature and date

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
Birth to present	☐ OUTPATIENT ☐ INPATIENT ☒ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Any medical facility or physician that has provided services to me TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
USAFSAM/IFCI/MFS	2510 Fifth St Wright Patterson AFB, OH 45433
c. TELEPHONE *(Include Area Code)* (937) 938-2867	d. FAX *(Include Area Code)* (937) 656-4006

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☒ OTHER *(Specify)* Military Flight Physical
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED
My entire medical record, including any and all mental health records. This includes but is not limited to AHLTA, CHCS, and MHS Genesis.
AUTHORIZATION START DATE: Date of flight physical administrative review.
Authorization complete upon final disposition and certification of exam by HQ AFAC/AM, IAW DAFMAN 48-123 08 December 2020.

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	☒ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*
	self	

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

Reset

Adobe Professional 8.0