Jeffrey D. Horn, MD
VISION FOR LIFE

PATIENT HISTORY

Referring Doctor: _____

Contact Information:

First Name:	**SS#:**	**Age:**	**DOB:**	**Gender:** M F
Last Name:		☐ **Best?**	**Home Phone:**	
Address:		☐ **Best?**	**Work Phone:**	
City: / **State:**	**ZIP:**	☐ **Best?**	**Cell Phone:**	
Employer:	**Marital Status:**	**Email:**		
Occupation:	**Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**		**Race:**	

Contact Information:

List any medications you take (including oral contraceptives and over the counter) *May use back of the form*:

Are you allergic to any medications? *Please list.*	**Yes** ☐	**No** ☐
Are you currently being treated for any medical condition?	**Yes** ☐	**No** ☐
Are you pregnant or nursing?	**Yes** ☐	**No** ☐
Do you smoke? If **Yes**, how much? **Yes** ☐ **No** ☐	Do you drink alcohol? **Yes** ☐	**No** ☐
Have you ever been diagnosed with or treated for MRSA?	**Yes** ☐	**No** ☐

HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAVE:

	Yourself			Immediate family				
General Eye Conditions	**Yes**	**No**	**General Medical Conditions**	**Yes**	**No**		**Yes**	**No**
Glaucoma			Diabetes					
Cataracts			High Blood Pressure					
Retinal Detachment/Disease			Heart Disease					
Lazy Eye/Amblyopia			Breathing Problems					
Eye Surgery			Auto-Immune Disease					
Dry Eye			Arthritis					
Eye Injury/Infection			Cancer					
Other (list):			Other (list):					

Eye History:

When was your last eye exam?	Doctors Name/City:	
How old are your present glasses?	Do you wear contacts?	How old are your contacts?
When do you use glasses/contacts?	Constantly ☐ Reading Only ☐ Distance Only ☐ Rarely ☐	

Pharmacy		**Primary Care Physician**	
Name:	Phone:	Name:	Phone:

Responsible Party (insurance):		**Emergency Contact:**
Name:		Name:
DOB:	SSN:	Phone:

PATIENT SIGNATURE: _____ **DATE:** _____