Jeffrey D. Horn, MD
VISION FOR LIFE • Your Cataract & Lasik Experts

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:	E-Mail:		
Occupation:		Ethnicity: ☐ Hispanic ☐ Non-Hispanic		Race:	

Medical History

List any medications you take (including oral contraceptives and over the counter):

Are you allergic to any medications? Yes No

Are you currently being treated for any medical condition? Yes No

Have you had COVID-19? Yes No

Have you had the COVID-19 Vaccine? Yes No
If Yes, Please list the dates of your COVID-19 vaccine: _____ _____

Are you pregnant or nursing? Yes No

Do you smoke? If yes, how much? Yes No

Have you ever been diagnosed with or treated for MRSA? Yes No

Have you ever had or been told that you have:

General Eye Conditions	Yes	No	General Health Conditions	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			Seasonal Allergies		
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? Yes No	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:**_____ Updated 7/22/2021