

Word of Mouth - Patient's Name:



Dr. Jonathan Spilkin Dr. Jason Facchin Dr. Elsa Budianto Dr. Jodi Kaplovitch

Your email address (for appointment reminders)  □ I consent to receiving appointment receils and reminders through phone, text, and email from University Eye Clinic. I understand that I may unsubscribe from any or all of these messages at any time.  Personal Past / Present Ocular History: (circle yes or no)  Glaucoma	□ Dr. □ Mr. □ Mr  Last Name:  First Name:  Date of Birth: M:  Sex: □ Male	D:			:  ode:		
Personal Past / Present Ocular History: (circle yes or no)  Glaucoma No Yes Eye Injury No Yes Cataracts No Yes Dry Eyes No Yes mild / mod / severe / with Cl Macular Degeneration No Yes Eye Surgery No Yes Smoker No Yes Medications: No Yes Allergies: No Yes Medications: No Yes (list):  Family Physician: Name: Address:  Personal Medical History: (circle if applies) or All Negative  Heart disease High cholesterol High blood pressure  Asthma COPD Sleep Apnea Pregnant x Months  Crohn's Ulcerative colitis IBS  Ankolysing Spondilitis Arthritis Rheum. Hepatitis A, B, C Birth Control? Y / N  Migraines With Aura Slogren's  Diabetes type 1 / 2 xyr Thyroid Stroke  HIW Lupus Psoriasis  Other/Details:  Family Ocular History:  Glaucoma No Yes  Macular Degeneration No Yes  Retinal Disease No Yes  Retinal Disease No Yes  Retinal Disease No Yes	To help us ensure yo	our histo	ory is accurate	we would app	preciate you	ır con	npleting the following:
□l consent to receiving appointment recalls and reminders through phone, text, and email from University Eye Clinic. I understand that I may unsubscribe from any or all of these messages at any time.  Personal Past / Present Ocular History: (circle yes or no)  Glaucoma No Yes Eye Injury No Yes Cataracts No Yes Dry Eyes No Yes mild / mod / severe / with Cl Macular Degeneration No Yes Eye Surgery No Yes  Macular Degeneration No Yes Medications: No Yes Allergies: No Yes Medications: No Yes  Allergies: No Yes Medications: No Yes  (list):  Family Physician: Name: Address:  Personal Medical History: (circle if applies) or All Negative  Heart disease High cholesterol High blood pressure  Asthma COPD Sleep Apnea Pregnant xMonths  Crohn's Ulcerative colitis IBS  Ankolysing Spondilitis Arthritis Rheum. Hepatitis A, B, C Birth Control? Y / N  Migraines Migraines with Aura Siggren's  Diabetes type 1 / 2 xyr Thyroid Stroke  HIV Lupus Psoriasis  Other/Details:  Family Ocular History:  Has any blood relative been diagnosed with? If Yes - Please indicate family member(s) beside condition(s)  Glaucoma No Yes  Macular Degeneration No Yes  Macular Degeneration No Yes  Retinal Disease No Yes	*How do you prefer to be		(e.g. Bill or Mr. Smith)				
Glaucoma  No Yes  Cataracts  No Yes  Dry Eyes  No Yes  Macular Degeneration  No Yes  Eye Surgery Procedure/Date:  Smoker  No Yes  Allergies:  No Yes  (list):  Circle if applies)  Address:  Personal Medical History:  (circle if applies)  Or All Negative  Heart disease  High cholesterol  Asthma  COPD  Sleep Apnea  Pregnant xMonths  Crohn's  Ulcerative colitis  Arthritis Rheum.  Migraines  Diabetes type 1 / 2 xyr  Thyroid  Stroke  HIV  Lupus  Psoriasis  If Yes - Please indicate family member(s) beside condition(s)  Glaucoma  No Yes  Macular Degeneration  No Yes  Macular Disease  Mo Yes  Macular Disease  Mo Yes  Macular Disease  Mo Yes  Macular Disease  No Yes  Macular Disease  No Yes  Macular Disease  Mo Yes  Macular Disease  Mighiar Macular Disease  Mo Yes  Macular Disease  Macular Disease  Mo Yes  Macular Disease  Macular Diseas	I consent to receiving appoint any or a	intment rec all of these	alls and reminders the messages at any time	e	nd email from Ur	 liversity	Eye Clinic. I understand that I
Cataracts No Yes Dry Eyes No Yes mild / mod / severe / with Cl Macular Degeneration No Yes Eye Surgery No Yes Procedure/Date:  Smoker No Yes Medications: No Yes (list):  Family Physician: Name: Address:  Personal Medical History: (circle if applies) or All Negative Heart disease High cholesterol High blood pressure Asthma COPD Sleep Apnea Pregnant xMonths Crohn's Ulcerative colitis IBS Ankolysing Spondilitis Arthritis Rheum. Hepatitis A, B, C Birth Control? Y / N Migraines Migraines with Aura Sjogren's Diabetes type 1 / 2 xyr Thyroid Stroke HIV Lupus Psoriasis  Other/Details: Family Ocular History: Has any blood relative been diagnosed with? If Yes - Please indicate family member(s) beside condition(s) Glaucoma No Yes Macular Degeneration No Yes Retinal Disease No Yes Retinal Disease No Yes			<b>-</b>	,	A.	V	
Macular Degeneration No Yes							"
Allergies:  No Yes (list):  Address:  Personal Medical History: Heart disease High cholesterol Asthma COPD Sleep Apnea Pregnant xMonths Crohn's Ulcerative colitis High blood pressure Asthma Arthritis Rheum. High cholesterol Sleep Apnea Pregnant xMonths Hepatitis A, B, C Birth Control? Y / N Migraines Diabetes type 1 / 2 xyr Thyroid Stroke HIV Lupus Psoriasis  Other/Details:  Family Ocular History: Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s) Glaucoma No Yes Macular Degeneration No Yes Retinal Disease No Yes Retinal Disease				Eye Surge	ery No		mila / moa / severe / with CLs
Allergies: No Yes (list):  Family Physician: Name: Address:  Personal Medical History: (circle if applies) or All Negative  Heart disease High cholesterol High blood pressure Asthma COPD Sleep Apnea Pregnant xMonths  Crohn's Ulcerative colitis IBS  Arthritis Rheum. Hepatitis A, B, C Birth Control? Y / N  Migraines Migraines with Aura Sjogren's  Diabetes type 1 / 2 xyr Thyroid Stroke  HIV Lupus Psoriasis  Other/Details:  Family Ocular History:  Has any blood relative been diagnosed with? If Yes - Please indicate family member(s) beside condition(s)  Glaucoma No Yes  Macular Degeneration No Yes  Retinal Disease No Yes	Smoker	No	Yes	Procedure	e/Date.		
Personal Medical History: (circle if applies) or All Negative  Heart disease		No		<u>Medicatio</u>		Yes	
Heart disease	Family Physician: N	ame:		Address:			
Asthma	Personal Medical Histo	ory:	(circle if applies	or All Ne	egative		
Crohn's Ulcerative colitis IBS  Ankolysing Spondilitis Arthritis Rheum. Hepatitis A, B, C Birth Control? Y / N  Migraines Migraines with Aura Sjogren's  Diabetes type 1 / 2 xyr Thyroid Stroke  HIV Lupus Psoriasis  Other/Details:  Family Ocular History:  Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s)  Glaucoma No Yes  Macular Degeneration No Yes  Retinal Disease No Yes	Heart disease		High cholesterol	Hig	gh blood pressure	9	
Ankolysing Spondilitis  Arthritis Rheum.  Migraines  Migraines with Aura  Sjogren's  Diabetes type 1 / 2 xyr  Thyroid  Stroke  HIV  Lupus  Psoriasis  Other/Details:  Family Ocular History:  Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s)  Glaucoma  No  Yes  Macular Degeneration  No  Yes  Retinal Disease  No  No  Yes  Migraines  Mig							Pregnant xMonths
Migraines Migraines with Aura Sjogren's Diabetes type 1 / 2 xyr Thyroid Stroke HIV Lupus Psoriasis  Other/Details:  Family Ocular History: Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s)  Glaucoma No Yes  Macular Degeneration No Yes  Retinal Disease No Yes							Rirth Control2 V / N
Diabetes type 1 / 2 xyr Thyroid Stroke  HIV Lupus Psoriasis  Other/Details:  Family Ocular History: Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s)  Glaucoma No Yes  Macular Degeneration No Yes  Retinal Disease No Yes							
Other/Details:   Family Ocular History:   Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s)   Glaucoma No Yes   Macular Degeneration No Yes   Retinal Disease No Yes    The state of the properties of t			-	-			
Family Ocular History: Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s)  Glaucoma No Yes  Macular Degeneration No Yes  Retinal Disease No Yes	HIV		Lupus	Ps	oriasis		
Has any blood relative been diagnosed with? If Yes – Please indicate family member(s) beside condition(s)  Glaucoma No Yes  Macular Degeneration No Yes  Retinal Disease No Yes	Other/Details:						
Macular Degeneration No Yes  Retinal Disease No Yes		n diagnos	ed with? If Yes -	Please indicate fa	amily member	(s) bes	ide condition(s)
Retinal Disease No Yes	Glaucoma	No	Yes				
	Macular Degeneration	No	Yes				
	Retinal Disease	No	Yes				
Referral Source: (New Patients) Who referred you to us?  Do you wear contact lenses? Yes No Rare							

Are you happy with them?

Yes No