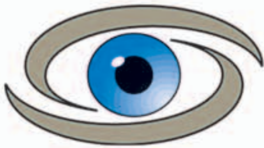

University Eye Clinic

Dr. Jonathan Spilkin
Dr. Peter Solo
Dr. Jason Facchin

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss.

Last Name: ______________________
First Name: ______________________

Date Of Birth: M: _____ D: _____ Y: _____

Sex: ☐ Male ☐ Female

Email Address: ______________________

Home Phone ( ) ______________
Bus. Phone ( ) ______________
(H) Address: ______________________
City: ______________________
Province: ______________________
Postal Code: ______________________

Occupation: ______________________

Employer: ______________________

Family Doctor: ______________________
Telephone Number: ______________________
Address: ______________________

Ontario Health Card: ______________________

How do you prefer to be addressed in this office?

(e.g. Bill or Mr. Smith) ______________________

Who referred you to us? (please circle)

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Patient Physician

Name: ______________________
Address: ______________________

Confidential Medical Information

Main reason for today's examination is:

____

____

Do You Have?	Yes	No
High Blood Pressure	☐	☐
Diabetes	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachments	☐	☐
HIV	☐	☐
Hepatitis	☐	☐
Asthma	☐	☐
Herpes Simplex/Zoster	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus/Autoimmune Disease	☐	☐

Other medical conditions: ______________

Any eye surgery or injuries? ☐ Yes ☐ No
Laser ☐ Other: ______________

Date ______________

Do you wear contact lenses? ☐ Yes ☐ No
Full Time ☐
Part Time ☐
What Brand? ______________

Are you happy with your current contact lenses? ☐ Yes ☐ No

Are you on any medications? ☐ Yes ☐ No
List of Medications: ______________________

Do you have any allergies? ☐ Yes ☐ No
List of allergies: ______________________

Family History	☐ Yes	☐ No	Which Member(s)?
Glaucoma	☐	☐	______________
Macular Degeneration	☐	☐	______________
Retinal Detachment	☐	☐	______________