

OWNER: Kim E Miller  
 ADDRESS (Street & No., City, Zip Code): Bnk Creekside  
 Animal Registered Name: HUMEHILL CREEKSIDE'S JENNA  
 Breed/Variety: LEBESITED BY THE EXAMINER Coat color/type: YELLOW Permanent ID#:



**CANINE EYE  
REGISTRATION  
FOUNDATION**

12/15/15  
**Cornell University**  
**Drs. Kern, Riis, and Irby**  
**College of Veterinary Medicine**  
**Cornell University Hospital for Animals**  
 Ithaca, NY 14853  
 (607) 253-3060

I hereby declare that the animal submitted for exam is the animal described above. Furthermore, I declare I am the owner or agent of the owner of this animal.

**REGISTRATION NO.**

S	R	0	0	2	3	3	4	0	0
0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

Signature: Kim

**PLACE ON  
HARD SURFACE  
AND PRESS  
FIRMLY WHEN  
WRITING.**

**SEX**  
 Male  Female

**BIRTH DATE**  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  
 DAY: 23 YEAR: 15

**EXAM DATE**  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  
 DAY: 2 YEAR: 16

**FOR CERF  
USE ONLY**

BREED: [ ] [ ] [ ] COLOR: [ ] [ ] [ ]

RIGHT EYE		LEFT EYE	
<b>GLOBE</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
microphthalmos			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dry eye			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma			
upper	lower	lower	upper
<b>EYELIDS</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
entropion			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ectropion			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
distichiasis			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ectopic cilia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eury/macro blepharon			
<b>THIRD EYELID</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cartilage anomaly/eversion			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gland prolapse			
<b>CORNEA</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dystrophy - epithelial/stromal			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dystrophy - endothelial			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
inherited pannus			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exposure/pigmentary keratitis			
<b>UVEA</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iris/ciliary body cyst			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iris coloboma			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pigmentary uveitis			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
persistent pupillary membranes			
CATARACT		CATARACT	
T	N	N	T
Diff. Inter. Punc.		Punc. Inter. Diff.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anterior cortex			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
posterior cortex			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
equatorial cortex			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anterior sutures			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
posterior sutures			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nucleus			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
capsular			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
generalized			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
significance of above punctate cataract unknown			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
subluxation/luxation			
<b>VITREOUS</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
persistent hyaloid artery			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHPV/PTVL			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
degeneration			

RIGHT EYE		LEFT EYE	
<b>FUNDUS</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal atrophy - generalized			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal atrophy - suspicious			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal dysplasia/retinopathy			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
choroidal hypoplasia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
staphyloma/coloboma			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal detachment			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal hemorrhage			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
optic nerve coloboma			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
optic nerve hypoplasia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
micropapilla			
<b>OTHER UNLISTED CONDITIONS</b>			
suspected as inherited. Describe in comments			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NORMAL</b>			



I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy.

Signature: Kim Date: 4/22/16

Diplomate, American College of Veterinary Ophthalmologists

**COMMENTS**

ACVO # 055