OPHTHALMOLOGY HISTORY FORM

1. Is your pet current on all vaccinations? □ Yes □ No

2. Is your pet taking heartworm preventative medication? □ Yes □ No

3. Has your pet traveled outside of New York? □ Yes □ No
   If yes, where and when? ______________________________________________________________________
   __________________________________________________________________________________________

4. Does your pet have any significant medical problems other than the eye(s)? ______________________
   __________________________________________________________________________________________

5. Are you currently treating your pet with any medications? □ Yes □ No
   If medications are being given, please list name(s), amount and frequencies: ______________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

6. Is your pet diabetic? □ Yes □ No
   If so, amount of insulin given: __________________________________________________________________

7. What leads you to believe your pet has an eye problem? ______________________________________
   __________________________________________________________________________________________
   Loss of vision: ______________________ More in dim light or bright light ______________________
   Eye discharge: □ Watery      □ Like pus      □ Thick and green
   Peculiar color to the eye(s)? □ Yes □ No
   If yes, please describe: ____________________________________________________________________
   Holds eye(s) closed □ Yes □ No    Veterinarian noted the problem □ Yes □ No
   Other: __________________________________________________________________________________
8. How long has the problem been present?

9. How well do you believe your pet sees?
   □ Excellent  □ Poor on all occasions
   Poor especially in:  □ Dim light  □ Bright light
   Poor in regard to:  □ Near  □ Distant objects
   Poor in regard to:  □ Moving  □ Stationary objects

10. Do you have other pets?  □ Yes  □ No
    If so, name the type of pet(s) and whether or not they have eye problems:

    ____________________________________________________ Eye problems □ Yes □ No
    ____________________________________________________ Eye problems □ Yes □ No
    ____________________________________________________ Eye problems □ Yes □ No
    ____________________________________________________ Eye problems □ Yes □ No

11. Do you know your pet’s dam or sire or littermates?  □ Yes  □ No
    If yes, do any of them have eye problems?  □ Yes  □ No  □ Do not know

12. Are you in the medical field?  □ Yes  □ No
    If yes, you are a  □ Physician  □ Dentist  □ RN  □ Other_______________________________