Name_____

Pet's Name_____

File #_____

Referring Veterinarian_____

Date _____

Long Island Veterinary Specialists

*Where You Take Your Pet First Makes All The Difference*

# 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: _____

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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
_____ 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

13. Are you in the medical field? ☐ Yes ☐ No
If yes, you are a ☐ Physician ☐ Dentist ☐ RN ☐ Other_____