Initial Eye Exam History

Date ____ / ____ / ____

1. Has either eye had any problems prior to this current eye problem?

☐ Yes ☐ No *If yes, which eye (s)?* ☐ Right ☐ Left ☐ Both

How long ago? ☐____weeks, ☐____months, ☐____years, ☐ do not know

2. What eye(s) currently has (have) the problem? ☐ Right ☐ Left ☐ Both

How long has the current eye problem been present? ☐____hours, ☐____days, ☐____weeks, ☐____months, ☐____years, ☐ do not know

3. Does your pet sleep with eyelids . . . . . ☐ open ☐ partially open ☐ closed ☐ do not know

4. Why do you believe there is an eye problem?

a. The ☐ Right ☐ Left ☐ Both is (are) held partially closed or squinted

b. The ☐ Right ☐ Left ☐ Both has (have) changed in overall color

The color of the eye (s) is (are) ☐ red ☐ gray ☐ white ☐ yellow ☐ green

c. The ☐ Right ☐ Left ☐ Both pupil(s) has(have) changed in size

d. The ☐ Right ☐ Left ☐ Both has (have) an eye discharge.

The eye discharge is ☐ fluid, watery or ☐ thick, viscous

The eye discharge is ☐ clear ☐ white, gray ☐ yellow, green or ☐ rust, brown, black

f. ☐ Eyes are rubbed with paw or along the furniture

g. Vision in the ☐ Right ☐ Left eye(s) seems to be ☐ gone (blind) or ☐ diminished (partially sighted)

h. Do **YOU FEEL** your pet is in pain? ☐ Yes ☐ No

If yes, why do you feel this way? _____

i. ☐ My veterinarian first noted the eye problem. The diagnosis was _____

j. ☐ Other

5. Does your pet exhibit any of these signs associated with vision loss?

☐ Yes ☐ No a. Runs into unfamiliar objects— "suddenly went blind in my neighbor's house."

☐ Yes ☐ No b. Refuses to move— "sleeps all day; seems old."

☐ Yes ☐ No c. Unwilling to jump or climb— "won't jump off the bed anymore."

☐ Yes ☐ No d. Unable to locate moving or stationary object— "can no longer catch his frisbee."

☐ Yes ☐ No e. Refusal to move in darkness— "outside at night, he just stands there."

☐ Yes ☐ No f. Develops aggressive behavior— "now growls at me when I walk into the house."

☐ Yes ☐ No g. Seeks security— "always at my feet."

☐ Yes ☐ No h. Altered gait— "he goose steps like a soldier on parade."

☐ Yes ☐ No i. Head carried low— "constantly sniffs the ground when he walks."

☐ Yes ☐ No j. None of the above

6. Travel History/Other: _____

_____

_____

_____

_____

_____

_____

Please Fill Out the Backside

General Eye Related Health Questions

7. Does your pet . . .

☐ Yes ☐ No a. Drink excessively

☐ Yes ☐ No b. Urinate excessively, make bladder mistakes in the house

☐ Yes ☐ No c. Eat excessively, constantly hungry

☐ Yes ☐ No d. Seem to be ☐ losing weight or ☐ gaining weight

8. Has your pet ever had ear problems? ☐ Yes ☐ No

If yes, how long ago? ☐____weeks, ☐____months, ☐____years, ☐ do not know

Is he currently experiencing an ear problem? ☐ Yes ☐ No

If yes, which ear(s) ☐ Right ☐ Left ☐ Both

a. **Does he shake his head?** ☐ Yes ☐ No ☐ Sometimes

b. **Does he walk around with a head tilt?** ☐ Yes ☐ No

If yes, does his head tilt to ☐ Right ☐ Left ☐ Both

c. **Does he yawn?** ☐ Yes ☐ No If yes, how many times a week _____

d. **How well does your pet hear?**

☐ Excellent, alerts to all sound

☐ Alerts to certain sounds but than looks around to find where the sound is originating

☐ Poor on all occasions. Does not alert to any sound

9. Has your pet ever had a . . .			**Treatment for the condition**
☐ Yes	☐ No	a. Dental cleaning	_____
☐ Yes	☐ No	b. Bad tooth or periodontal disease	_____
☐ Yes	☐ No	c. Hyperthyroidism or other hormone related disease	_____
☐ Yes	☐ No	d. Hypertension	_____
☐ Yes	☐ No	e. Bladder or other urinary tract disease	_____
☐ Yes	☐ No	f. Pancreatic disease, like pancreatitis	_____
☐ Yes	☐ No	g. Liver disease, like hepatitis	_____
☐ Yes	☐ No	h. Gastrointestinal disease (vomiting &/or diarrhea)	_____
☐ Yes	☐ No	i. Nervous system disease	_____
☐ Yes	☐ No	j. Upper respiratory disease	_____
☐ Yes	☐ No	k. Other, Describe _____	

10. If your pet plays with toys, does he violently shake his head during his play? ☐ Yes ☐ No

11. Is current lab work available ☐ Yes ☐ No ☐ Describe abnormalities _____

_____

12. Current Treatment being administered

Antibiotics: ☐ topical _____ times/day x _____ days ☐ oral_____ times/day x _____ days

Steroids: ☐ topical _____ times/day x _____ days ☐ oral_____ times/day x _____ days

Other: _____

☐ topical _____ times/day x _____ days ☐ oral_____ times/day x _____ days

Other: _____

☐ topical _____ times/day x _____ days ☐ oral_____ times/day x _____ days

13. Other Comments: _____

_____

_____

_____

_____

OFFICE USE ONLY: ☐ Medical / Legal