Garden State Veterinary Specialists

Ophthalmology History Form

Please complete this form with a ball point pen. You may use the reverse side if additional space is needed.

OWNER ______________________________ PET'S NAME _______________________ DATE _____________

1. **Which eye is affected?** ☐ Right ☐ Left ☐ Both eyes
2. **What leads you to believe your pet has an eye problem? (Choose all that apply)**
   - ☐ Decrease in vision
   - ☐ Squinting (holding eye closed)
   - ☐ Rubbing or pawing at eye
   - ☐ Eye discharge
     - ☐ watery ☐ thick ☐ gray ☐ green/yellow
   - ☐ Peculiar color to the eye
     - ☐ cloudy/white ☐ cloudy/blue ☐ red
   - ☐ Veterinarian noted the problem
   - ☐ Other ____
3. **How long has the problem been present?**
   ☐ Days (_____) ☐ Weeks (_____) ☐ Months (_____) ☐ Years (_____)
4. **Has the character of the eye problem changed since you first were aware of it?** ☐ Yes ☐ No
   If yes, please describe: ____
5. **How would you classify your pet's vision?**
   - ☐ Excellent
   - ☐ Poor on all occasions
   - ☐ Poor especially in dim light
   - ☐ Poor especially in bright light
   - ☐ Poor for near objects
   - ☐ Poor for distant objects
6. **Please list any/all medications your pet receives, including amounts and frequency.**
   ____
   ____
7. **Please list any other significant medical problems other than the eyes.** **(Ex. Heart murmur, kidney disease)**
   ____
   ____
8. **Has your pet traveled outside of the New York/New Jersey area?** ☐ Yes ☐ No
   If yes, where and when? ____
9. **Do you know any of your pet's relatives?** ☐ Yes ☐ No
   If yes, do any of them have eye problems? ☐ Yes ☐ No
   If yes, explain ____
10. **Is your pet current on vaccinations?** ☐ Yes ☐ No
11. **Does your pet receive flea/tick and heartworm preventative medications?** ☐ Yes ☐ No