



Ophthalmology History

First and last name:

Address:

Name of the pet:

Species:

Breed:

Sex:

Age:

Current body weight of your pet: kg lb

Date:

E-mail address:

Phone number:

Your local veterinarian name and contact info:

1. What are the observed eye problems?

Eye discharge Holds eye closed Rubbing Pain/squinting

Swelling of eyelids Change of the eye color Known injury

Decreased vision Loss of vision In dark In bright light

Decreased vision for near objects far objects moving objects

Other eye problems not listed:

Describe the onset of problems and duration:

Which eye is affected? right left both

2. Current and previous eye medications:

3. Response to eye medications: improving same getting worse

Diarrhea Soft stool Blood in the stool Since:

Coughing Problems with breathing Since:

9. Does your pet have any history of allergies? Yes No

Food Seasonal Drugs Vaccine Anesthesia

If yes, please describe:

10. Did your pet ever have any autoimmune disease? Yes No

If yes, please specify type of disease and date when disease was diagnosed and treated:

11. Did you notice any of following clinical symptoms in your pet in recent months? Problems with hearing Problems with smell sensation

Abnormal mentation or behavior Abnormal walk or posture

If yes, please describe:

12. Did your pet have general anesthesia in the last 12 months? Yes No

13. Did your pet have ever any cancer/mass diagnosed, removed or treated in the past?

Yes No If yes, please provide more details (type of cancer, treatment, date of diagnosis):

14. When was the last vaccination?

15. Please list the name, frequency and last date when heartworm medications were given?

16. What is the current diet that you are giving to your pet?

17. Please list any other information which may be pertinent to the overall health of your pet: