

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

- | | | |
|--|--|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | a. Dental cleaning | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Bad tooth or periodontal disease | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Hyperthyroidism or other hormone related disease | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | d. Hypertension | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | e. Bladder or other urinary tract disease | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Pancreatic disease, like pancreatitis | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Liver disease, like hepatitis | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Gastrointestinal disease (vomiting &/or diarrhea) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | i. Nervous system disease | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | j. Upper respiratory disease | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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:** _____

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