Submit Form

ANIMAL EYE CONSULTANTS OF IOWA
SEE THE WORLD

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

4. **Has your pet had any other eye problems medically or surgically treated in the past?** ☐Yes ☐No If yes, please describe:

5. **Do you know of any eye problems in your pet's dam, sire or littermates?**

   ☐Yes ☐No If yes, please describe:

6. **Do you have any other pets?** ☐Yes ☐No If yes, did any of your pets was recently ill or had any eye problems? ☐Yes ☐No If yes, please describe:

7. **Has your pet had any other health problems in the last 12 months?** ☐Yes ☐No

   Please check the organ system:

   ☐heart/lung/ high blood pressure

   ☐brain/spinal cord ☐kidneys/urinary tract ☐immune system/blood

   ☐teeth/stomach/intestines ☐skin ☐joints/bone/muscle

   ☐endocrine glands (☐thyroid ☐adrenal/Cushing's ☐diabetes ☐other)

   ☐cancer

   If yes, please specify:

   Please list any systemic medications, heartworm medications, flea preventatives or food supplements currently used:

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8. **Did you notice any of following clinical symptoms in recent months**:

   ☐Yes ☐No If yes, please select the appropriate category:

☐Excessive drinking and urination Since:

☐Increased hunger and/or weight gain Since:

☐Vomiting Since:

☐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: