OPHTHALMIC HISTORY FORM

How old was your pet when it was acquired and where was your pet acquired?_____

Is your pet currently vaccinated? Yes No

Are there other pets in the household? (If yes, what are they?)_____

Are your pets indoor &/or outdoor? (circle one)

Does your pet travel out of Oregon? Yes No

When did your pet's eye problem begin?_____

What symptoms have you observed at home?

Squinting? Rubbing?

Tearing/discharge? Decreased vision?

Redness?

What procedures/treatments have been performed by your veterinarian?

_____

_____

_____

_____

Please list all the medications that your pet has received in the past 3 months:
(Drugs, dosage and how frequently given)

_____

_____

_____

Please list any other medical problems and duration of these conditions:

Arthritis? Thyroid dysfunction?

Skin disease? Seizures?

Ear problems? Tumors?

Dental disease? Diet?