



**Name:**  
**Phone:**

**Animal Name:**  
**Species:**  
**Sex:**

**Breed:**  
**Age:**

### Ophthalmic Client Questionnaire

What lead you to believe your pet had an eye problem?

- Loss of vision
- Eye discharge
- Squinting (holding eye shut)
- Change in color or cloudiness
- My veterinarian noticed the problem (specify) \_\_\_\_\_
- Other: \_\_\_\_\_

How long has the problem been present? \_\_\_\_\_

Which eye is affected?

- Right
- Left
- Both

Has the problem changed since you first became aware of it?

- Yes: If yes, how has it changed? \_\_\_\_\_
- No

Have you treated the eye with any medications?

- Yes: If yes, please list ALL medications and how often they are being administered.

Medication \_\_\_\_\_ How often? \_\_\_\_\_

Medication \_\_\_\_\_ How often? \_\_\_\_\_

Medication \_\_\_\_\_ How often? \_\_\_\_\_

- No medications being given

Your pet's eye sight seems to be:

- Excellent
- Fair
- Poor on occasions
- Poor in dim/dark light
- Poor with objects nearby
- Poor with objects far away

Do you have other pets?

- Yes: If yes, do they have any eye problems? \_\_\_\_\_
- No

Has your pet had any other eye problems in the past?

- Yes : If yes, what type? \_\_\_\_\_
- No

Does your pet suffer from any other illness?

- Yes: If yes, what type? \_\_\_\_\_
- No

Is your pet currently receiving any other medications?

- Yes: If yes, please list \_\_\_\_\_
- No

#### Office Use

STT: OD: \_\_\_\_\_ OS: \_\_\_\_\_

Caution: yes / no / poss

Fluorescein stain: OD: \_\_\_\_\_ OS: \_\_\_\_\_

WT: \_\_\_\_\_ kg

IOP: OD: \_\_\_\_\_ OS: \_\_\_\_\_