

ANIMAL OPHTHALMOLOGY CLINIC, LTD.

CLIENT HISTORY QUESTIONNAIRE

Owner's Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Employer: _____ DL#: _____

Name of Animal: _____ Referring Veterinarian: _____

Species: Dog Cat Horse Other: _____

Breed: _____ Sex: _____ Age: _____

Color: _____ Neutered: Yes No

Please complete both sides of the following questionnaire. Answer all questions to the best of your knowledge. Approximate dates are acceptable. Thank you for your help.

1. Describe the complaint: _____

2. Which eye(s) is (are) involved? (circle one) R L Both

3. If both are involved, which was involved first? (circle one) R L Both

4. Onset: (check one) sudden gradual

5. When did you first notice the problem? _____

6. Does your pet have trouble seeing? _____ If so, describe the extent: _____

7. Have you noticed that your pet's vision is worse at a particular time of the day or night or in bright or dim lighting conditions?
_____ If yes, please describe: _____

8. Is the problem worse at certain times of the year than others? _____

9. Is the problem painful or irritating to your pet? _____

10. Do you know of animals related to your pet which have similar problems? _____
If so, how are they related? _____
11. Is your pet mostly: (check one) indoors outdoors partly in and out
12. (a) Do you have small children in the household? (check one) yes no
(b) Do you have other pets in the household? _____

- Do they have similar eye problems? _____
Do they have other illnesses? _____
13. Describe the pet's diet (type and amount): _____

14. Have you noted any changes in the amount of water your pet drinks? (check one)
 Increased Decreased No change Don't know If so, please describe the degree of change: _____

15. Have you noticed any changes in urination? _____ If so, please describe: _____

- Does your pet have accidents in the house? _____
16. What treatment(s) has your pet received, and how long has it been receiving the treatment(s)? _____

17. Have the treatments helped? _____
18. When did your pet last receive treatment and what was it? _____

19. Does your pet have any other medical problems? _____

20. Does your pet show any other abnormal signs? _____
