Ophthalmology Questionnaire

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Patient:          Owner:          Date:

Please answer these questions to the best of your knowledge so we may serve you and your pet better.

1) What is your pet’s problem with its eye/eyes?
   Please check all that apply.

   ______ Cataracts       ______ Eyelid Mass       ______ Redness
   ______ Cherry Eye      ______ Grey Coloration  ______ Scratch
   ______ Decreased Vision ______ High Pressure   ______ Squinting
   ______ Eye Discharge   ______ Injury         ______ Eye Mass
   ______ Pain           ______ Don’t Know      ______ Other

   Other (Please Describe):

   __________________________________________________
   __________________________________________________

2) How long ago did you first notice the problem with the eye/eyes?
   Please indicate with a specific number if possible.

   ______ Hours   ______ Weeks       ______ Since Birth
   ______ Days    ______ Years       ______ Don’t Know

3) What previous medical problems has your pet had?
   Please check all that apply.

   ______ No Significant Medical History
   ______ Allergies        ______ Arthritis       ______ Cancer
   ______ Coughing         ______ Cushing’s Disease  ______ Dental Disease
   ______ Diabetes         ______ Diarrhea        ______ Heart Disease
   ______ Kidney Disease   ______ Nasal Discharge  ______ Seizures
   ______ Sneezing         ______ Thyroid Hormone High ______ Thyroid Hormone Low
   ______ Vomiting         ______ Weight Gain     ______ Weight Loss
**Continued**

Please describe other medical issues we should be aware of:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4) What medications does your pet currently take?
   Please include all medications.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

5) Do you feel that any current medications have helped your pet?
   Yes    No    Not Applicable

   If no, please explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6) Do you feel that your pet will allow you to give eye drops or apply eye ointment?
   Yes    No    Not Applicable

7) Has your pet ever traveled outside of New York State?
   Yes    No    Not Applicable

   If yes, when and where did your pet travel?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

8) Is your pet an indoor or outdoor pet?
   Strictly indoors    Indoors and outdoors
   Indoors mainly, but also on porch    Outdoors mainly, but with shelter

9) Is your pet up-to-date on vaccinations?
   Yes    No    Don’t Know