New Ophthalmology Patient Questionnaire

Emergency & Specialty Hospital
Where care comes first.

Date: _____

Place Label Here

Name: _____ Pet's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

1. What is the problem with your pet's eye(s): _____

_____

2. Please circle: Is it the right, left, or both eyes affected?

3. Has your pet had an eye problem or surgery prior to this one?_____

_____

4. When did the problem begin? _____

5. If you have noticed any of the following, please circle:

Redness Cloudiness Squinting Sudden/slow change in vision

Discharge from the eye(s) – describe: watery, clear, thick, yellow, mucous

Rubbing at the eye(s)

6. Please circle if your pet is having any of the following:

Vomiting, diarrhea, coughing, sneezing, change in appetite, change in drinking, change in urination, change in defecation

7. Please list all medications and supplements that your pet is taking, including those not for the eye:

Name of Medication	Route	Frequency	Duration of use
(Ex. Ofloxacin)	**(Ex. Right/Left Eye)**	**(Ex. 3x/day)**	**(Ex. 2 Weeks)**

8. Do you have any additional concerns? _____

_____