ANIMAL VISION CENTER of VIRGINIA

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So they can see a better life.

Patient History

Name of Patient: _____ **Date:** _____

Name of Person Providing History: _____

Which eye is affected? ☐ Right ☐ Left ☐ Both Eyes

How long has this problem been present? _____

What problems have you noticed?

☐ Loss of Vision
☐ Eye Discharge
☐ Squinting (Holding eye shut)
☐ Change in color or cloudiness
☐ My veterinarian noticed the problem (specify) _____
☐ Other _____

Has the problem changed since you first became aware of it? ☐ Improved ☐ Worsened ☐ Stayed about the same

Your pet's eyesight seems to be:

☐ Excellent
☐ Fair
☐ Poor on occasions
☐ Poor in dim/dark light
☐ Poor with objects nearby

Have you treated the eyes with any medications (over-the-counter or prescription)? ☐ Yes ☐ No

List any medications and how often:

_____
_____
_____

Has your pet had other eye problems in the past? ☐ Yes ☐ No

If yes, what type? _____

Does your pet have any other illness(es)? ☐ Yes ☐ No

If yes, what type? _____

Is your pet receiving any other medication(s)? ☐ Yes ☐ No

If yes, please list? _____

Best contact number today? _____

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