



# NEW CLIENT FORM

Thank you for giving Eye Care for Animals the opportunity to care for your pet.  
So that we may become better acquainted, please complete the following:

Mr. Mrs.  
Ms. Dr. Responsible Party #1 \_\_\_\_\_ Responsible Party #2 \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_ Cell/Pager # ( ) \_\_\_\_\_

Email Address \_\_\_\_\_ Drivers License (For Checks) \_\_\_\_\_

Employer #1 \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Employer #2 \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Hospital \_\_\_\_\_

Regular Doctor (if different than above) \_\_\_\_\_ Hospital \_\_\_\_\_

## PET INFORMATION

Please complete the following for the pet we are seeing today:

Name of Pet \_\_\_\_\_ Dog/Cat/other \_\_\_\_\_ Breed \_\_\_\_\_

Approximate Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Spayed/Neutered \_\_\_\_\_ Color \_\_\_\_\_

Known Drug Allergies: \_\_\_\_\_

Other Medications Your Pet Is Taking: \_\_\_\_\_

I authorize and direct the veterinarians at the *Eye Care* FOR ANIMALS to diagnose, prescribe, perform minor therapeutic procedures, that their judgement may dictate to be advisable for the patient's well being. No warranty or guarantee has been made as to the result or cure.

**ALL FEES ARE REQUIRED TO BE PAID IN FULL UPON COMPLETION OF THE VISIT.**

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost included in said unpaid balance, including a reasonable collection and/or attorney's fees.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

# Initial Eye Exam History

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**1. Has either eye had any problems prior to this current eye problem?**

Yes  No *If yes, which eye (s)?*  Right  Left  Both

*How long ago?*  \_\_\_\_ weeks,  \_\_\_\_ months,  \_\_\_\_ years,  do not know

**2. What eye(s) currently has (have) the problem?**

Right  Left  Both

*How long has the current eye problem been present?*  \_\_\_\_ hours,  \_\_\_\_ days,  \_\_\_\_ weeks,  \_\_\_\_ months,  \_\_\_\_ years,  do not know

**3. Does your pet sleep with eyelids . . . . .**

open  partially open  closed  do not know

**4. Why do you believe there is an eye problem?**

a. The  Right  Left  Both is (are) held partially closed or squinted

b. The  Right  Left  Both has (have) changed in overall color

The color of the eye (s) is (are)  red  gray  white  yellow  green

c. The  Right  Left  Both pupil(s) has (have) changed in size

d. The  Right  Left  Both has (have) an eye discharge.

The eye discharge is  fluid, watery or  thick, viscous

The eye discharge is  clear  white, gray  yellow, green or  rust, brown, black

f.  Eyes are rubbed with paw or along the furniture

g. Vision in the  Right  Left eye(s) seems to be  gone (blind) or  diminished (partially sighted)

h. Do **YOU FEEL** your pet is in pain?  Yes  No

If yes, why do you feel this way? \_\_\_\_\_

i.  My veterinarian first noted the eye problem. The diagnosis was \_\_\_\_\_

j.  Other

**5. Does your pet exhibit any of these signs associated with vision loss?**

Yes  No a. Runs into unfamiliar objects— “suddenly went blind in my neighbor’s house.”

Yes  No b. Refuses to move— “sleeps all day; seems old.”

Yes  No c. Unwilling to jump or climb— “won’t jump off the bed anymore.”

Yes  No d. Unable to locate moving or stationary object— “can no longer catch his frisbee.”

Yes  No e. Refusal to move in darkness— “outside at night, he just stands there.”

Yes  No f. Develops aggressive behavior— “now growls at me when I walk into the house.”

Yes  No g. Seeks security— “always at my feet.”

Yes  No h. Altered gait— “he goose steps like a soldier on parade.”

Yes  No i. Head carried low— “constantly sniffs the ground when he walks.”

Yes  No j. None of the above

**6. Travel History/Other:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Fill Out the Backside 

# General Eye Related Health Questions

## 7. Does your pet . . .

- Yes  No a. Drink excessively  
 Yes  No b. Urinate excessively, make bladder mistakes in the house  
 Yes  No c. Eat excessively, constantly hungry  
 Yes  No d. Seem to be  losing weight or  gaining weight

## 8. Has your pet ever had ear problems? Yes No

If yes, how long ago?  \_\_\_ weeks,  \_\_\_ months,  \_\_\_ years,  do not know

Is he currently experiencing an ear problem?  Yes  No

If yes, which ear(s)  Right  Left  Both

a. Does he shake his head?  Yes  No  Sometimes

b. Does he walk around with a head tilt?  Yes  No

If yes, does his head tilt to  Right  Left  Both

c. Does he yawn?  Yes  No If yes, how many times a week \_\_\_\_\_

d. How well does your pet hear?

- Excellent, alerts to all sound  
 Alerts to certain sounds but than looks around to find where the sound is originating  
 Poor on all occasions. Does not alert to any sound

## 9. Has your pet ever had a . . .

### Treatment for the condition

- |  |  |       |
|--|--|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | a. Dental cleaning                                   | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Bad tooth or periodontal disease                  | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Hyperthyroidism or other hormone related disease  | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | d. Hypertension                                      | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | e. Bladder or other urinary tract disease            | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Pancreatic disease, like pancreatitis             | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Liver disease, like hepatitis                     | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Gastrointestinal disease (vomiting &/or diarrhea) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | i. Nervous system disease                            | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | j. Upper respiratory disease                         | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | k. Other, Describe _____                             | _____ |

10. If your pet plays with toys, does he violently shake his head during his play?  Yes  No

11. Is current lab work available  Yes  No  Describe abnormalities \_\_\_\_\_

## 12. Current Treatment being administered

Antibiotics:  topical \_\_\_\_\_ times/day x \_\_\_\_\_ days  oral \_\_\_\_\_ times/day x \_\_\_\_\_ days

Steroids:  topical \_\_\_\_\_ times/day x \_\_\_\_\_ days  oral \_\_\_\_\_ times/day x \_\_\_\_\_ days

Other: \_\_\_\_\_

topical \_\_\_\_\_ times/day x \_\_\_\_\_ days  oral \_\_\_\_\_ times/day x \_\_\_\_\_ days

Other: \_\_\_\_\_

topical \_\_\_\_\_ times/day x \_\_\_\_\_ days  oral \_\_\_\_\_ times/day x \_\_\_\_\_ days

13. Other Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OFFICE USE ONLY:  Medical / Legal