ANIMAL EYE CLINIC

PATIENT HISTORY

Date: ____ /____ /_____

PATIENT NAME _____

CLIENT/OWNER INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Best Phone: _____ Secondary Phone: _____ Email: _____

Referring Clinic & Veterinarian _____

PATIENT INFORMATION

DOB or Age: _____ Species: _____ Breed: _____

Sex: ◯ Male ◯ Female Neutered/Spayed? ◯ Yes ◯ No Weight: _____

PATIENT HISTORY

Which eye is affected? ◯ Left Eye ◯ Right Eye ◯ Both Eyes

What problems have you noticed? (check all that apply)

☐ Squinting ☐ Eye Discharge/Watering ☐ Loss of Vision ☐ Change of Color/Cloudiness

☐ Other: _____

How long has this problem been occurring? _____

Has your pet received treatment for this problem? ◯ Yes ◯ No

If Yes, please list medications and how often they are administered:

Has the problem changed since becoming aware of it? ◉ Improved ◯ Worsened ◯ Stayed the same

Other health conditions and/or medications?

Fees are payable in full at time services are rendered. Acceptable forms of payment include: Cash, Debit or Major Credit Cards (Visa, MasterCard, Discover, American Express). **Sorry, No Checks.**

Note: Fees charged reflect the quality and value of our advanced and specialized medical and surgical services, and include the expertise required to diagnose and treat your pet, and the cost of the diagnostic, therapeutic and surgical equipment utilized. Written estimates will be provided for patients for which surgery and/or advanced diagnostic procedures under sedation or general anesthesia are recommended.