# 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 ________________

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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: ________________

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Other Medications Your Pet Is Taking: ________________

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I authorize and direct the veterinarians at *Eye Care for Animals* to diagnose, prescribe, and perform minor therapeutic procedures that their judgment may dictate to be advisable for the patient's well being. No warranty or guarantee has been made as to the result or cure. Eye Care for Animals (ECFA) may share your pet's medical information with your referring, specialty, or primary veterinarians and other ECFA agents for the purpose of continuity of treatment or for research purposes. By signing below, you authorize ECFA to share your pet's medical records as outlined above.

**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 costs included in said unpaid balance, including a reasonable collection and/or attorney's fees.

Signature of Responsible Party ________________ Date ________________

Eye Care®
FOR ANIMALS
Seeing life through your pet's eyes

# 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:** ________________________________

# 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 then 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**

☐ Yes ☐ No a. Dental cleaning ____________________
☐ Yes ☐ No b. Bad tooth or periodontal disease ____________________
☐ Yes ☐ No c. Hyperthyroidism or other hormone related disease ____________________
☐ Yes ☐ No d. Hypertension ____________________
☐ Yes ☐ No e. Bladder or other urinary tract disease ____________________
☐ Yes ☐ No f. Pancreatic disease, like pancreatitis ____________________
☐ Yes ☐ No g. Liver disease, like hepatitis ____________________
☐ Yes ☐ No h. Gastrointestinal disease (vomiting &/or diarrhea) ____________________
☐ Yes ☐ No i. Nervous system disease ____________________
☐ Yes ☐ No j. Upper respiratory disease ____________________
☐ Yes ☐ 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**