OPHTHALMOLOGY DEPARTMENT

1053 S. CLEVELAND-MASSILLON ROAD, AKRON, OH 44321
Phone: (330) 576-3899 Fax: (330) 666-0519
E-Mail: eyesakron@metropolitanvet.com

Please give this information to the receptionist when completed. THANK YOU!

Today's Date: ________________ Appointment time: _____________

***Client Information* (Please fill out all blanks applicable):**

Have you ever been to this clinic before? YES NO If yes, when: _________ Pet Name: ____________

OWNER'S NAME: ______________________________

ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

HOME TEL NUMBER: ______________________________

WORK TEL NUMBER: ______________________________

CELL PHONE NUMBER: ______________________________

EMERGENCY NUMBER: ______________________________

OCCUPATION: ____________________ EMPLOYER: ____________________

DRIVERS LICENSE NUMBER: ____________________ EMAIL ADDRESS: ____________________

Pet Information:

PET NAME: ______________________________

SPECIES **(circle one)**: Canine or Feline Other: ______________ Breed: ____________________

AGE: _______ BIRTH DATE: _______ SEX **(circle one)**: Male or Female / Male-Neutered or Female-Spayed

COLOR/MARKINGS: ____________________ WEIGHT: ____________________

ANY KNOWN ALLERGIES: ______________________________

Regular Veterinarian:

NAME: ______________________________

PRACTICE: ______________________________

LOCATION: ______________________________

TELEPHONE: ____________________ FAX: ____________________

Patient Background:

Is your pet *People* Aggressive? YES NO

Is your pet *Dog* Aggressive? YES NO

Your Pet's Attitude: Gentle Requires Muzzle Prefers Men Prefers Women

Any Known Allergy? ____________________

How long have you owned your pet? ____________________

Diet: Circle all that apply: Can Dry Semi Moist Table Food

Brand:____________________

Current Vaccinations: Yes No Date of last vaccination: ____________________

Has your pet traveled out-of-state? Yes No

Where? ____________________

Are there any other pets in your household? Yes Describe:
No ____________________

Is your pet indoor/outdoor or both? ____________________

Please describe your pet's eye problem(s) - past and present:

____

____

____

How long has your pet's eye problem been occurring? __________Days __________Weeks

Have there been any changes in your pet's (Circle and describe below)

Appetite: **Yes** **No** **Increased** **Decreased** Describe: ____________________

Water Intake: **Yes** **No** **Increased** **Decreased** Describe: ____________________

Urinations: **Yes** **No** **Increased** **Decreased** Describe: ____________________

Bowel Habits: **Yes** **No** **Increased** **Decreased** Describe: ____________________

Vomiting: **Yes** **No** **Increased** **Decreased** Describe: ____________________

Coughing: **Yes** **No** **Increased** **Decreased** Describe: ____________________

Seizures/Convulsions: **Yes** **No** **Frequency**_________ Describe: ____________________

Changings in Walking: **Yes** **No** **Wobbly** **Arthritis** Describe: ____________________

Skin Changes: **Yes** **No** **Itching** **Redness** **Rash** Describe: ____________________

Tumors/Swellings: **Yes** **No** Location and Describe: ____________________

Other: Describe: ______________________________

What medication(s) is your pet taking?

____

____

What are the current medications and when were they last given?

____

Past Medical Problems (include surgery, trauma, medical conditions...diabetes, heart failure, etc.):

____

____

Did your regular veterinarian give you any information for the doctor to review?

☐ Referral letter and summary ☐ X-rays ☐ Copies of test results

Financial Consent:

I assume all financial responsibility for the INITIAL treatment/diagnostic testing for my pet. I understand that the hospital policy is payment in full at the time my pet is released. If further testing will be needed, an estimate of cost will be provided during the initial consultation. This estimate will fluctuate as changes in treatment are instituted. A deposit will be required prior to treatment. By signing below, I understand that payment in full is due at time of my pet's release and will most likely pay by: (circle one) CASH CHECK VISA MC DISCOVER AMERICAN EXPRESS CARE CREDIT

Signed: ______________________________ Date: ____________________

Examination Consent:

I do hereby authorize the Ophthalmology Service/Metropolitan Veterinary Hospital and its veterinarians and their assistants to treat my pet in the manner that is considered to be necessary based on their INITIAL clinical and/or diagnostic findings. I authorize the administration of necessary treatments and/or diagnostic tests if needed. Any other diagnostics or tests will be discussed with you by the clinical staff prior to service.

Signed: ______________________________ Date: ____________________