

Sudden Acquired Retinal Degeneration Syndrome / Immune-Mediated Retinopathy Questionnaire

Date: _____ Pet's Name: _____ Pet's current weight: _____ lbs / kgs

Client's Last Name: _____ First Name: _____

VISION

Describe vision problems and duration: _____

Problems with vision in the dark? **YES / NO** In bright light? **YES / NO**

Complete loss of vision? **YES / NO** Since when: _____

HEALTH HISTORY

Increased urination/drinking? **YES / NO** Since when: _____

Increased hunger/weight gain? **YES / NO** Since when: _____

Allergies? **YES / NO** **FOOD / SEASONAL** Since when: _____

Describe neurologic signs such as problems hearing, smelling, walking, posture, etc:

History of tumors? **YES / NO** Please describe: _____

Previous anesthesia? **YES / NO** When: _____

Previous surgeries? **YES / NO** Reason: _____ When: _____

MEDICATION

Is your pet currently taking medication? **YES / NO** If YES, please list medication(s) and when the last dose was given:

Response to medication: **NONE / GETTING BETTER / GETTING WORSE** Please explain: _____

GENERAL

Diet: _____

Last vaccination: _____ Last heartworm medication: _____