Hope Animal Hospital

History Form Tech_____ Receptionist_____

Client Name: _____ **Patient Name:** _____

Contact number(s): _____

Reason for your visit today: _____

Do you authorize lab work? Yes / No
Do you authorize X-rays? Yes / No
Would you like an estimate of charges for today's visit? Yes No Client given estimate? [ ]
How long have you noticed these symptoms? _____ **Frequency?** _____
Are these symptoms improving, getting worse, or the same? _____

Please indicate your pet's level of discomfort today:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Have you noticed any of the following?	**Please circle**		**For how long?**
Vomiting	Yes	No	_____
Weight loss	Yes	No	_____
Weight gain	Yes	No	_____
Increased Urination	Yes	No	_____
Coughing	Yes	No	_____
Sneezing	Yes	No	_____
Nasal Discharge	Yes	No	_____
Stiffness/Limping/Lameness (LF/RF/LR/RR)	Yes	No	_____
Behavioral/Attitude Changes	Yes	No	_____
Soft Stools/Gas	Yes	No	_____
Fleas/Ticks	Yes	No	_____
Itching/Licking/Chewing (Where)	Yes	No	_____
Shaking Head	Yes	No	_____
Skin/Hair/Coat Changes	Yes	No	_____

Ventral (Bottom) **Dorsal (Top)**

Growths or Lumps (Use picture to the left)

Appetite: Increased Decreased No change

Water consumption: Increased Decreased No change

Activity Level: Increased Decreased No change

What medications or supplements do you give your pet? _____

Has your pet been given any medications today? Yes / No **If so, which one(s) and at what time?**

_____

Has your pet been fed today? Yes/No **What type of food do you feed your pet?** _____

Is your pet allergic to any medications? _____ **Do you need any medication refills?** Yes/No

Owner Signature: _____**Date:** _____