

Client

Patient

Patient's Age

Date

COMPREHENSIVE PET HISTORY



Come. Heal. Stay well.

Please Circle Your Answers

Are your address and phone number still correct? Yes No

If no, please list changes _____

Reason for visit _____

When did this problem start? _____

Has your pet been seen for the same condition recently? Yes No

Are vaccinations up to date? Yes No

Any behavior changes? Yes No

If yes, please describe _____

Do you brush your pet's teeth? Yes No

Does your pet have bad breath? Yes No

Has your pet been tested for internal parasites within the past six months? Yes No

Is your pet on heartworm preventative? Yes No

Is your pet on flea control? Yes No

Does your pet have a history of seizures? Yes No

Is your pet currently on any medications? Yes No

If yes, please list _____

Is your pet allergic to any drugs/vaccinations? Yes No

If yes, please list _____

Diet/Treats _____

How much do you feed your pet daily? _____

Does your pet have any food intolerances? Yes No

If yes, please list _____

Did your pet eat this morning? Yes No

Appetite Normal Increased Decreased

Weight Stable Gain Loss

Water Consumption Normal Increased Decreased

Bowel Movements Normal Constipated Diarrhea

How Long? _____

Urination Normal Increased Amount

Straining Increased Frequency

Please Circle Your Answers

Does your pet have any of the following?

Vomiting Yes No

Coughing Yes No

Sneezing Yes No

Gagging Yes No

Stiffness Yes No

Lameness Yes No

Weakness Yes No

Listlessness Yes No

Hair Loss Yes No

Scratching Yes No

Shaking Head Yes No

Scotting Yes No

Lumps or Discharge Yes No

If yes to any of the above, please describe frequency & character

Anything else we need to know?

Do you want any of the following procedures performed?

Ears Cleaned (\$17.00) Yes No

Anal Glands Expressed (\$19.00) Yes No

Nails Trimmed (\$16.00 - Dog / \$12.00 - Cat) Yes No