

COMPREHENSIVE PET HISTORY

Is your address & phone number still correct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If first visit, is this your first pet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you aware pet insurance is available?	<input type="checkbox"/> Yes <input type="checkbox"/> No Company _____
Chief complaint or reason for visit?	<input type="checkbox"/> Annual Exam _____
Has the pet been seen for the same condition lately?	<input type="checkbox"/> Yes <input type="checkbox"/> No (How Long? _____)
Are vaccinations up to date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the pet spayed / neutered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the pet been tested for internal parasites within past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the pet on heartworm preventive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you seen the pet passing any worms?	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Any injury or illness in past 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Does the pet have a history of having seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the pet currently on any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Is the pet allergic to any drugs / medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No List: _____

DIET: _____ How many times a day do you feed your pet? _____

PET TREATS: _____

Does the pet get table scraps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any food intolerances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did your pet eat this morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Appetite:	<input type="checkbox"/> Increased	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased
Weight:	<input type="checkbox"/> Loss	<input type="checkbox"/> Stable	<input type="checkbox"/> Gained
Water consumption:	<input type="checkbox"/> Increased	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased
Bowel movements?	<input type="checkbox"/> Constipated	<input type="checkbox"/> Normal	<input type="checkbox"/> Diarrhea (How long? _____)
Urination?	<input type="checkbox"/> Decreased	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased amount <input type="checkbox"/> Increased freq.
Straining to urinate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Incontinence? (Loss of House Training) <input type="checkbox"/> Yes <input type="checkbox"/> No
Vomiting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Coughing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Panting? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sneezing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gagging?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any listlessness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any weakness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Shaking head?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Scratching?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(Location: _____)
Significant hair loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Patchy <input type="checkbox"/> Generalized <input type="checkbox"/> Excessive shedding
Flea control used?	<input type="checkbox"/> Frontline®	<input type="checkbox"/> Advantage®	<input type="checkbox"/> Program® <input type="checkbox"/> Other: _____
Scotching?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Unusual lumps or bumps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bad breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Unusual discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(Location: _____)
Lameness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Which leg?	<input type="checkbox"/> RF <input type="checkbox"/> LF	<input type="checkbox"/> RR <input type="checkbox"/> LR	
Difficulty rising?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
After sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
After exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Difficulty Climbing Stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stiffness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any behavioral changes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(Describe: _____)

Anything else we need to know? _____

I hereby authorize the hospital to prescribe for and treat the conditions presented on this form for the pet presented by me. The hospital and staff will not be held liable for any problems that develop provided that reasonable care is provided. Further I agree to pay fees in full for services rendered when pet is discharged from the hospital's care unless other prior arrangements have been agreed upon by both parties.

Signature _____

Date _____