Comprehensive Pet History

Pet: _____ Owner: _____ Date ___/___/___

Are your address & phone number still correct? ❑ no ❑ yes

If this is your first visit, is this your first pet? ❑ no ❑ yes

Are you aware that pet insurance is available? ❑ no ❑ no, tell me more ❑ yes

Has your pet been microchipped? ❑ no ❑ no, but I am interested ❑ yes

Are you interested in a tour of the hospital? ❑ no ❑ yes

Are you planning on boarding or grooming your pet within the next 6 months? ❑ no ❑ yes

Reason for today's visit? ❑ Annual wellness exam & vaccines ❑ other _____

Has your pet been seen for the same condition recently? ❑ no ❑ yes, when _____

Are your pet's vaccinations up to date? ❑ no ❑ yes ❑ don't know

Is your pet spayed or neutered? ❑ no ❑ yes ❑ don't know

Has your pet's stool been checked for parasites within the last 6 months? ❑ no ❑ yes ❑ don't know

Have you seen any worms in your pet's stool? ❑ no ❑ yes, describe _____

Is your pet on heartworm prevention? ❑ no ❑ yes, year round ❑ yes, part of the year

What product(s) do you use? _____

What day of the month do you give the heartworm prevention? _____

Is your pet on flea prevention? ❑ no ❑ yes, year round ❑ yes, part of the year

What product(s) do you use? _____

Has your pet had any illness or injury within the last 30 days? ❑ no ❑ yes, describe _____

_____

Is your pet currently on any medications? ❑ no ❑ yes, list _____

Any known allergies to drugs/medications? ❑ no ❑ yes, list _____

What dental care do you provide at home? _____

How often? _____

What do you feed your pet? (list brand and amount) _____

What treats do you feed your pet? _____

What table scraps do you feed your pet? _____

Does your pet have any food intolerances? ❑ no ❑ yes, describe _____

Did your pet eat this morning? ❑ no ❑ yes Appetite: ❑ decreased ❑ normal ❑ increased

Weight: ❑ loss ❑ stable ❑ gain Water consumption: ❑ decreased ❑ normal ❑ increased

Bowel movements: ❑ constipated ❑ normal ❑ diarrhea

Urinations: ❑ decreased ❑ normal ❑ increased amount ❑ increased frequency ❑ straining ❑ incontinence (loss of housetraining)

Vomiting: ❑ no ❑ yes Coughing: ❑ no ❑ yes Excessive panting: ❑ no ❑ yes

Difficulty breathing: ❑ no ❑ yes Sneezing: ❑ no ❑ yes Gagging: ❑ no ❑ yes

Listlessness/lethargy: ❑ no ❑ yes Weakness: ❑ no ❑ yes Shaking head: ❑ no ❑ yes

Scratching: ❑ no ❑ yes, location _____

Significant hair loss: ❑ no ❑ patchy loss ❑ generalized loss ❑ excessive shedding

Scooting: ❑ no ❑ yes Bad breath: ❑ no ❑ yes

Lumps or bumps: ❑ no ❑ yes, describe location _____

Unusual discharge: ❑ no ❑ yes, describe location _____

Lameness: ❑ no ❑ yes Which leg: ❑ RF ❑ RR ❑ LF ❑ LR

Difficulty rising: ❑ no ❑ yes Difficulty climbing stairs: ❑ no ❑ yes Stiffness : ❑ no ❑ yes

Behavioral changes: ❑ no ❑ yes, describe _____

Is your pet having any other problems or issues that you would like to discuss with the doctor today?

_____