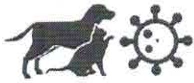

Medical History Form

Date:

CLIENT INFORMATION:

Client Name:

Address:

Phone: Home Cell Work:

Email:

PATIENT INFORMATION:

Pet Name: Breed:

Species: Dog Cat Other Color:

Sex: M F Date of Birth:

Spayed/Neutered: YES NO

PATIENT HISTORY:

Describe your concern:

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How long has it been going on? DAYS WEEKS MONTHS

What are you currently feeding your pet?

How is their appetite? POOR GOOD EXCELLENT

When did they eat last?

Are you currently giving any medications or supplements? If so: NAME/DOSE/LAST GIVEN

Any coughing or sneezing? If so, please describe:

Any vomiting or diarrhea? If so, please describe:

Have they gotten into anything? Eaten anything unusual?

Is your pet indoors only? (CATS) YES NO

Any environmental changes?

How is their behavior? LETHARGIC NORMAL HYPERACTIVE

Any changes to thirst? INCREASED NORMAL DECREASED

Any changes to urination? INCREASED NORMAL DECREASED

How are their bowel movements? NORMAL ABNORMAL

When was their last bowel movement?

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