Animal Medical Center of Seattle

Oncology Department Patient History Form

Please complete this form to the best of your knowledge. Thank you!

Owner Name_____Patient Name_____

Problem/Complaint_____

Is your pet up-to-date on vaccines?_____Yes_____No

Recent treatments for current problem_____

Current Medications:

1._____Dose_____How often_____Last given_____

2._____Dose_____How often_____Last given_____

3._____Dose_____How often_____Last given_____

4._____Dose_____How often_____Last given_____

What are you feeding your pet? Please include any supplements, vitamins, or herbs_____

_____

_____

Any known allergies?_____If so please explain_____

_____

Is it ok to give your pet treats during your appointment? (We've been known to give cookies to our patients☺)_____

_____

In recent history have you noticed any changes in…(Please circle what applies)

Drinking: (Increased/Decreased/Normal)

Appetite: (Increased/Decreased/Normal)

Weight: (Increased/Decreased/Normal)

Energy: (Increased/Decreased/Normal)

Urination: (Increased/Decreased/Normal)

Defecation: (Increased/Decreased/Normal)

Coughing: (Increased/Decreased/Normal)

Pain/Lameness: (Increased/Decreased/Normal)

Vomiting: (Yes/No) If yes, how often?_____

Other comments_____