University Veterinary Hospital & Diagnostic Center

New Pet Medical History Form

Owner's Name*

Patient's Name*

Is your pet on any medications?*

Yes

No

If Yes please list the names and dosages:

Does your pet have any sensitivity to any medications or any foods?*

Yes

No

If Yes please describe:

What food are you currently feeding?*

Canned or Dry?*

Is your pet spayed or neutered?*

Yes

No

If Yes at what approximate age?

Who is your previous veterinarian?*

May we contact them for records?*

Yes

No

Date of last vaccinations?*

Has your pet been diagnosed with any of the following diseases? (Select all that apply)*

Allergies

Arthritis

Cancer

Diabetes

Heart Disease

Kidney Disease

Liver Disease

Seizures

Signs of Injury

Thyroid Disease

Other:

Has your pet had any significant illnesses, surgeries, or injuries in the past? Please Describe...*

Do you have any specific concerns about your pet's health or care?