



Information about your healthy pet for today's appointment:

Your name:

Your pet's name:

Date:

Best way to reach you?

Phone (list times available and numbers)

Home:

Time:

Cell:

Time:

Work:

Time:

E mail:

How do you prefer we report your pet's fecal & heartworm tests to you? Phone Mail E-mail

How do you prefer to receive other communications from doctors and staff? Phone Mail E-mail

Overall Health:

Does your pet have any allergies to food, vaccines, or medications? Yes No

If yes, please describe:

Please mark any symptoms or concerns you have about your pet's health today.

Concerns or changes?			Comments
Is your pet under the care of another veterinarian or health care professional?	Yes	No	Name of Hospital or Doctor?:
Is your pet on medications or supplements?	Yes	No	
What do you feed your pet?			
What treats do you give your pet?	Yes	No	
Changes in eating/ appetite?	Yes	No	
Diet change in the past month?	Yes	No	
Weight change?	Yes	No	
Changes in drinking/water consumption	Yes	No	
Changes in urination?	Yes	No	
Skin changes/itching/rash/lumps?	Yes	No	
Eyes redness/squinting/discharge/ vision change?	Yes	No	
Ears/head shaking/scratching/odor?	Yes	No	
Breathing/coughing/sneezing/gagging?	Yes	No	
Teeth/gums/breath odor?	Yes	No	
Legs or back/pain/arthritis?	Yes	No	
Vomiting?	Yes	No	
Normal stools?	Yes	No	
Housebreaking concerns?	Yes	No	
Spayed or neutered?	Yes	No	
Changes with reproductive organs?	Yes	No	
Scotting?	Yes	No	
Attitude or behavior changes?	Yes	No	
Weakness/Loss of balance?	Yes	No	
Other?	Yes	No	

Client Name

ID

Date

Staff initials

Dr

(OVER)

Today's Visit:

Is your pet current on vaccinations and worming/fecal examinations? Yes No Due on:
Does your pet need any of the following?

Fecal Heartworm test Nail Trim Microchip (\$27) Vaccines
Other?

Does your pet need any medications refilled? Yes No

Flea Tick Heartworm Ear Thyroid

History:

Lifestyle: Indoor Outdoor Companion dog Performance dog Breeding dog Service dog

Describe his or her housing and lifestyle:

Does your pet travel? In state Out of state Board Dog events Locations:

Name of your previous veterinary clinic:

Phone: Fax:

Are there tests or x-rays from a previous illness or injury? No Yes

If you are new to us, may we request records from your previous veterinarian? Yes No

Reason you are not at your previous veterinary clinic today?

Emergency care not available Dissatisfied with service Dissatisfied with medical care

Did not have available appointment Services offered here they do not offer there

Other:

Symptoms:

Do you have any concerns about your pet's health? No Yes *If yes, please review below:*

When was your pet last normal?

What symptoms have you noticed?

What symptoms did you notice first? How long ago?

Are the symptoms getting better/ worse/ staying the same?

Has your pet been treated for this condition in the past? Describe medications and responses:

Is your pet acting normally? Yes No *If no, please describe:*

Are there observations or concerns we did not include in the questions above?

Do you have pet health insurance? No Yes Name of provider?

Preferred method of payment?

Cash Check Mastercard VISA Discover CareCredit

Reviewed as accurate on:(*date*) Owner initials: Date: Owner initials:

Reviewed as accurate on:(*date*) Owner initials: Date: Owner initials:

Reviewed as accurate on:(*date*) Owner initials: Date: Owner initials:

Client Name ID Date Staff initials Dr