

Patient History

Pet's Name: _____ Owner's Name: _____
Date: _____ Time: _____

Problem/complaint: _____
When did this problem start? _____

Has your pet been treated for any medical or surgical problems previous to this visit? _____
If yes, describe _____
How long have you owned your pet? _____
Other pets in the household? _____

Is your pet: female / male? spayed or neutered?
If not spayed when was her last heat? _____ Is she pregnant? yes / no

When was your pet last vaccinated against viral diseases? _____ Rabies? _____
Cats only: Has your cat been tested for FELV/FIV? yes / no Results? _____

Is your pet currently receiving medications to prevent heartworm/fleas/ticks?
Please list type of medication used _____

Is your pet indoor/outdoor/both _____ If outdoors are they supervised? _____
Do they have neighborhood access? yes / no

Has your pet had access to raw fish? yes/ no Access to garbage? yes / no

What kind of food does your pet normally eat? _____
Access to table scraps or meat bones? yes / no If yes please specify _____

Has your pet traveled outside of the Pacific Northwest? _____
When/where? _____

Is your pet currently taking any medications? (please include any pain medications, vitamins/supplements)

Has your pet ever had a reaction to or side effects from a medication? _____

Has your pet ever had a seizure? yes / no

Please turn over and complete page 2

The following questions are based on the last 24-48 hours

Has there been any change to your pet's energy level or behavior recently? yes/no

If yes, please describe _____

Has there been an increase or decrease in your pet's appetite recently? (circle one if applicable)

Has there been an increase or decrease in your pet's water intake recently? (circle one if applicable)

Has your pet had any access to toxins: yes / no When? _____
Type/amount _____

Has your pet had any vomiting? yes / no
When did it start? _____
How often, how much? _____

Has your pet defecated? yes / no When was the last normal stool? _____
Any diarrhea? yes / no Any straining? yes / no Any blood? yes / no

Does your pet have a history of urinary problems? yes / no
Is your pet urinating more frequently than normal? yes / no
Any straining to urinate? yes / no
Any blood in the urine or discoloration? yes / no

Is your pet coughing? yes / no When did it start? _____
Describe _____

Is your pet sneezing? yes / no When did it start? _____
Is there any nasal discharge or bleeding? _____