All Creatures Veterinary Care Center

CANINE & FELINE PATIENT HISTORY FORM

Date_____

CLIENT INFORMATION

Patient Name_____Patient ID _____

Owner Name_____

DIET AND ENVIRONMENT

What food does patient currently eat?_____ Amount & Frequency? _____

Does patient consume treats? **Yes/No** What kinds? _____

Is patient on any dietary supplements? **Yes/No** If so, what kind and what dosage? _____

Does patient consume table food? **Yes/No** Please explain. _____

Is patient primarily indoor or outdoor? _____

Are there any other animals in the household? **Yes/No** If so, are any of them sick? _____

Do you board your pet? **Yes/No** If so, how often? _____

Do you have your pet groomed or bathed outside of your home? **Yes/No** If so, how often? _____

REVIEW OF SIGNS

Has patient exhibited any attitude or behavior change? **Yes/No** Please explain. _____

Has patient ever had seizures? **Yes/No** Please explain. _____

Any recent appetite changes? **Yes/No** Please explain. _____

Does patient have any exercise intolerance? **Yes/No** Please explain. _____

Has patient had a decrease in urination? **Yes/No** Please explain. _____

Any recent weight changes? **Yes/No** Please explain. _____

Has patient been vomiting? **Yes/No** Please explain. _____

Has patient had any diarrhea? **Yes/No** Please explain. _____

Has patient been coughing? **Yes/No** Please explain. _____

Has patient been sneezing? **Yes/No** Please explain. _____

Has patient exhibited any signs of lamesness? **Yes/No** Please explain. _____

Does patient have difficulty rising after lying down? **Yes/No** Please explain. _____

Has patient been itching? **Yes/No** Please explain. _____

Has patient had any recent hair loss? **Yes/No** Please explain. _____

Does patient have any growths on body? **Yes/No** Please explain. _____

Does patient have any discharge from nose, eyes, vulva, etc.? **Yes/No** Please explain. _____

Has patient had any change in sleep patterns? **Yes/No** Please explain. _____

REASON FOR VISIT (FOR SICK PATIENTS)

When did the problem start or how long has the problem been occurring? _____

_____

_____

(OVER →)

All Creatures Veterinary Care Center

What were the first signs of the problem and how did it progress?_____

_____

_____

Was patient seen by another doctor for this problem? **Yes/No** If so, when? _____

_____

_____

Were any treatments given by you or another doctor? **Yes/No** If so, what and at what dosage? _____

_____

_____

PAST HISTORY (FOR NEW PATIENTS)

How long have you had the patient? _____ If you acquired patient recently, from where?

_____

Has patient traveled recently to or from New Jersey (within 6 months)? **Yes/No** If so, where and when?

_____

Has your patient been microchipped? **Yes/No** If so, has the microchip been registered? _____

Is patient on flea prevention? **Yes/No** If so, what type and how often? _____

Is patient on heartworm prevention? **Yes/No** If so, what type and how often? _____

Has patient been tested for heartworms? **Yes/No** If so, when? _____

Has the patient been exposed to ticks? **Yes/No** Please explain. _____

Is patient used for hunting? **Yes/No** Is patient taken camping or on outdoor trips? **Yes/No**

Is patient used for breeding? **Yes/No** If so, is she pregnant or is he currently standing? **Yes/No**

Has patient had any prior illnesses, accidents, or surgeries? **Yes/No** Please explain. _____

_____

Is patient aggressive or fearful around strangers? **Yes/No** Please explain. _____

Aside from heartworms, flea & tick preventatives, is patient given any other medication? **Yes/No** Please explain.

_____

Does patient have any known allergies to any medications? **Yes/No** If yes, please list: _____

_____

Has patient ever had a reaction to any vaccines? **Yes/No** If yes, please list and explain below:

_____

Owners Signature _____ Date _____