Comprehensive Patient Medical History Form

Pet's Name_____

E-mail address_____
Please provide us with your email address so we can provide you with special offers and healthcare reminders for your pet(s)

Phone Numbers:_____

Reason for today's visit:
_____

Has your pet been seen at another clinic for the same condition? □Yes □No

If yes, where? _____

When? _____

Is your pet currently taking any medication?
□ Yes □ No

If yes, what? _____

_____

What are you currently feeding your pet?
_____

Weight_____

Pet is ____% Indoor ____% Outdoor

Other pets in the household?

_____ Dogs _____ Cats _____ Others

Have you traveled with your pets recently?
□ Yes □ No

If so, where? _____

When did your pet last receive heartworm preventative? _____

Today's service will be paid by:
□ Cash □ Credit Card □ Care Credit

If your pet is experiencing any of the following please place an "x" in the box.

□ Vomiting	□ Dental problem/bad breath	□ Limping or pain
□ Change in appetite		□ Behavioral change
□ Breathing problems	□ Skin lump	□ Sneezing
□ Shaking	□ Ear problems	□ Weakness
□ Excessive licking	□ Coughing	□ Scratching
□ Eye problems	□ Changes in urination	□ Hair loss
□ Diarrhea/constipation	□ Lethargy	□ Bleeding
□ Change in water intake	□ Scooting	□ Seizures

Does your pet have any allergies that you are aware of? □Yes □No

If yes, please describe: _____

Anything else you would like to add? _____
_____