Current Patient History Form

Owner: _____ **Date:** _____

Pet Name: _____ **Age:** _____

Breed: _____ **Color:** _____

Sex: ☐ Male ☐ Female ☐ Spayed / Neutered?

Your pet is: ☐ Indoor ☐ Outdoor ☐ Both **Number of Dogs/Cats in the home:** _____

How may litterboxes? _____ ☐ N/A **Type of cat litter:** _____ ☐ N/A

Is your pet up to date on vaccines? ☐ Yes ☐ No ☐ Unsure

Is your pet on any Flea/Tick/Heartworm Prevention? ☐ Yes _____ ☐ No ☐ Unsure

Does your pet take any medications or supplements? ☐ Yes _____ ☐ No ☐ Unsure

Do you need any medication refills? ☐ Yes _____ ☐ No ☐ Unsure

Does your pet have any allergies (medical or environmental)? ☐ Yes _____ ☐ No ☐ Unsure

Do you have pet insurance? ☐ Yes_____ ☐ No ☐ Unsure

Food Brand: _____ ☐ Dry ☐ Canned **Amount fed daily:** _____

How is your pets appetite? ☐ Normal ☐ Other: _____

How is your pets attitude? ☐ Normal/Happy/Active ☐ Depressed/Lethargic ☐ Other: _____

Is your pet drinking? ☐ Normally ☐ More than usual ☐ Less than usual

Do you notice any of the following? ☐ None/Normal ☐ Coughing ☐ Sneezing ☐ Vomiting ☐ Diarrhea

☐ Limping ☐ Head Shaking/Scratching ☐ Eye Discharge ☐ Nasal Discharge ☐ Scooting ☐ Scratching

☐ Lumps ☐ Weight Loss ☐ Bad Breath ☐ Lethargy/Weakness ☐ Seizures ☐ Hairloss

☐ Pain or Straining to Urinate or Defecate

What is todays exam for? _____

_____

_____

How long has it been going on? _____

_____

Have you tried anything at home or given anything to your pet? ☐ Yes _____ ☐ No

Would you like to add services to your visit? Nail Trim ☐ Yes ☐ No Anal Gland Expression ☐ Yes ☐ No