

Canine/Feline Medical History - New Patient

Date: _____ Name: _____ Pet's Name: _____

Pet's Age: _____ Pet's Breed: _____ Pet's sex: _____

Phone Number: _____ Email: _____

Address: _____

Spayed or Neutered Pet Fur color: _____

History:

Is your pet experiencing any issues? If so, what are they? When did they begin?

Does your pet take any medications or supplements? No Yes If yes, what?

What vaccines has your pet had and when were they last given?

Is your pet on Heartworm Prevention? No Yes

TriHeart Revolution Trifexis Advantage Multi Other _____

Is your pet on flea and tick control? No Yes

Seresto Collar Bravecto Simparica Nexguard Advantage Other _____

Do you need any refills? No Yes _____

What type of food does your pet eat? _____

How much and how often? _____

Treats? Yes No Table food? Yes No

Any change in your pet's eating or drinking habits? No Change Increased Decreased

Any change in your pet's urination or bowel movements?

No Change Increased Decreased Diarrhea Constipated Accidents

From where did you obtain your pet? Shelter Breeder Other _____

How long have you had your pet? _____

Has your pet had previous health problems? No Yes Unknown If

yes, please describe:

Does your pet have a history of adverse reactions to vaccinations or medications? Yes If

No yes, please describe?

Has your pet ever had any surgeries? _____

Describe your pet's environment: Indoor Outdoor Indoor/Outdoor Other _____

Do you bathe your pet? No Yes Medicated baths Regular Grooming

Do you have any other pets in the household? No Yes _____

Has your pet had contact with any other animals in the past 30 days? _____

Has your pet traveled in the past 6 months? _____

Does your pet have any allergies? No Yes _____

Has your pet been spayed or neutered? Yes No Unknown

Does your pet have a microchip? Yes No