

Canine/Feline Medical History Sheet

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

Your phone number: _____

Has your address/phone number/email address changed since your last visit? No Yes (write below)

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?

Does your pet have a current Rabies Vaccine? No Yes Other Vaccinations? No Yes

Is your pet on Heartworm Prevention? No Yes
TriHeart ProHeart Trio Revolution Other _____

Is your pet on flea and/or tick control? No Yes
Seresto Collar Bravecto Simparica Revolution Comfortis 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

Has there been any change in your pet's eating or drinking habits? No Change Increased Decreased

Any change in urination or bowel movements?
No Change Increased Decreased Diarrhea Constipated Accidents

Does your pet have a history of adverse reactions to vaccinations or medications? No Yes If yes, please describe?

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

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 _____

Does your pet have a microchip? Yes No