

Pet History Form

The most important aspect of the drop-off service is the history provided by the client. Please take the time to fill out this form completely. This questionnaire allows the owner to provide information we commonly need to help our patients. Since our patients cannot talk, the information you provide will hopefully allow us to avoid delays in treatment and unnecessary or expensive testing.

Pet's Name: _____ Date: _____

Owner's Name: _____ (please limit to **one** person)

Phone Number: _____ (please limit to one number)

Reasons for today's visit: _____

Please select any that apply to your pet and explain on provided comment line:

Vomiting?	Yes / No	Bile	Food	Mucus	Blood	Foreign Material	For how long?
Diarrhea?	Yes / No	Blood		Mucus			For how long?
Constipated?	Yes / No						For how long?
Coughing?	Yes / No						For how long?
Sneezing?	Yes / No		Discharge: Yes / No				For how long?
Lethargy?	Yes / No		Scale: 1 (normal) – 10 (severe) ____				For how long?
Appetite?			Any change in diet?				For how long?
Thirst?							For how long?
Urination?		Discoloration		Straining			For how long?
Limping?	Yes / No				Sudden in onset?		For how long?
Skin problems?	Yes / No	Bumps	Redness	Itch			For how long?
Ear problems?	Yes / No	Shaking	Redness	Discharge	Odor		For how long?
Eye problems?	Yes / No	Squinting	Discharge	Color			For how long?

When did your pet last eat? _____

Have they eaten anything they shouldn't have? What? When? _____

Please add comments from above and/or give other pertinent information:

Please list **ALL** medications / supplements your pet is taking:
