COMPREHENSIVE PET HISTORY

Please answer these questions to help the veterinarian better know what is going on with your pet today. Thank you.

Pet's Name:_____ Date:_____

Is your address & phone number still correct? (Yes / No) Please update:_____
Would you like to receive reminders via email? (Yes / No) Email address:_____
Pet Insurance Company: _____(disregard if pet is not insured)
Does your pet have a microchip? (Yes / No)
Chief Complaint or Reason for Visit; please provide as much history and description of symptoms as possible:
_____

_____
Has the pet been seen for same condition previously? (Yes / No)
Please explain:_____
Injuries or illness in past 30 days? _____
Are vaccinations up to date? (Yes / No)
Circle one please: My pet is... Spayed Neutered Intact
Has the pet been tested for internal parasites within past 6 months? (Yes / No)
Heartworm Preventative used?_____ Date Last Administered:_____
Flea Control Used? _____ Date Last Administered:_____
Tick Control Used?_____ Date Last Administered:_____
Have you seen the pet passing any worms? (Yes / No) Describe: _____
Does the pet have a history of having seizures? (Yes / No)
Is the pet currently on any medications? (Yes / No) List: _____
Is the pet allergic to any drugs/medications/vaccines? (Yes / No) List: _____
Has your pet traveled outside of the immediate area over the past 6 months: (Yes / No) Where? _____
Has your pet been exposed to anyone testing positive for COVID-19 within the last 14 days? (Yes / No)
Where does your pet spend time? (circle one) Indoors Enclosed back yard Free roams/Acreage
Do you visit dog parks, walk around the neighborhood, or visit other public places with your pet? (Yes / No)
Other pets in household? [ ] Dogs [ ] Cats [ ] Livestock [ ] Reptiles [ ] Birds [ ] Small Mammals
Food (brand/formula): _____ Amount fed:_____ How many times per day?_____
Treats (brand/type): _____ Amount fed per day:_____
Dental Homecare products: _____
Does the pet get "people food"? (Yes / No)
Are there any food intolerances? (Yes / No) If so, what?_____
Did your pet eat this morning? (Yes / No) How much?_____

Circle any of the following that relate to your pet's current condition:

Decreased Appetite Increased Appetite Weight Loss Weight Gain Increased Water Consumption

Decreased Water Consumption Constipation Diarrhea Increased Urination Decreased Urination

Straining to Urinate Vomiting Coughing Sneezing Gagging Lethargy

Weakness Head Shaking Scratching Hair loss Scooting Lumps or Bumps

Bad Breath Unusual Discharge Lameness Stiffness Aggression Behavioral Changes

If you circled any of the clinical signs above, please describe when it began, the severity, and which part of your animal's body is of concern. Please also include any additional information that you may want the Doctor to know:

_____
_____