Client #: ________

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 circle 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	Productive / Dry Day / Night	For how long?____
Sneezing?	Yes / No	Discharge: Yes / No	For how long?____
Lethargy?	Yes / No	Scale: 1 (normal) – 10 (severe) ___	For how long?____
Appetite?	Increased / Decreased / No Change	Any change in diet? _____	For how long?____
Thirst?	Increased / Decreased / No Change		For how long?____
Urination?	Increased / Decreased / Discolored / Straining / No Change		For how long?____
Limping?	Yes / No	Front / Rear Left / Right 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? Yes / No 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:

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