

Today's date: _____

Patient Information Sheet

To help us provide the best possible care for your pet, please fill out one of these forms for each of your animals:

Owner's name: _____ Pet's name: _____

Species: Dog Cat Other: _____ Sex: Male Female Spayed or neutered? _____

Age/Date of birth: _____ Breed: _____ Color: _____

Reason for this visit: _____

How long has it been since your animal's last veterinary appointment? _____

What was done at that time? _____

To the best of your knowledge, please fill out the following information:

Dates of last vaccinations:

Dog

Distemper (DHP) _____
Parvo _____
Corona _____
Rabies _____
Bordetella _____

Dates of last vaccinations:

Cat

Distemper (FVRCP) _____
Feline Leukemia _____
Rabies _____

Has your animal ever had any of the following? (check those that apply):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Coughing spasms | <input type="checkbox"/> Allergies | <input type="checkbox"/> Growths | <input type="checkbox"/> Reactions to vaccinations |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Tumors | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Runny eyes | <input type="checkbox"/> Muscular weakness | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Heartworms | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Lameness | <input type="checkbox"/> Bleeding episode |

Is your pet currently on heartworm preventative? Yes No What kind? _____

Is your pet currently on flea/tick preventative? Yes No What kind? _____

Please list any known medical problems: _____

Is your animal currently receiving any medication? _____

Does your pet have any allergies to any medications? _____

What does your animal's diet primarily consist of? _____

Has your animal ever given birth? _____ When? _____

Have there been any recent changes in the animal's environment? _____

Has your animal exhibited recent changes in his/her physical behavior? _____

Is your animal sensitive to touch in any part of the body? _____

Has your animal ever exhibited hostile behavior? _____

Has your animal every had a negative veterinary experience? _____

Do you have any fear of veterinary treatment for your animal? _____

Do you know what needs to be done to handle your pet's medical situation? _____

What is the most important thing you want us to know about your animal to best meet his health care needs? _____