

DROP-OFF PATIENT HISTORY FORM: <date>

Owner's Name: \_\_\_\_\_ Pet's Name: \_\_\_\_\_
Species: \_\_\_\_\_ Breed: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_
Home: \_\_\_\_\_ Today's Phone#: \_\_\_\_\_

- Did your pet eat this morning? No / Normal / Less
• Is your pet on heartworm prevention? No / Yes
• Is your pet on flea prevention? No / Yes
• Please list other medications that your pet is taking \_\_\_\_\_
• Please list medications that you need refilled \_\_\_\_\_

AUTHORIZED DIAGNOSTIC TESTS

- Blood Work  Heartworm Test  Other \_\_\_\_\_
 Urinalysis  Leukemia & FIV Test \_\_\_\_\_
 Fecal Parasite Test  X-Ray \_\_\_\_\_

RECENT HISTORY

(Please check off problem(s) then circle or write in symptoms detailing how long and/or how often for each symptom)

- Eye problem (L/R/Both): redness, discharge, vision loss, \_\_\_\_\_
 Ear problem (L/R/Both): odor, discharge, discomfort, \_\_\_\_\_
 Nose problem: discharge, sneezing, \_\_\_\_\_
 Mouth/throat problem: odor, redness, bleeding, \_\_\_\_\_
 Respiratory problem: coughing, difficulty breathing, \_\_\_\_\_
 Abdominal problem: vomiting, discomfort, swelling, \_\_\_\_\_
 Skin problem: itching, hair loss, redness, crusts/scabs, bumps, wounds, \_\_\_\_\_
 Limping: L Front / R Front / L Rear / R rear, \_\_\_\_\_
 Urinary problem: straining, frequent, bloody, \_\_\_\_\_
 Bowel problem: diarrhea, bloody stool, mucousy stool, worms, \_\_\_\_\_
 Neurological problem: seizure, staggering, circling, \_\_\_\_\_
 Behavior problem: \_\_\_\_\_
 Appetite problem: increased, decreased, \_\_\_\_\_
 Weight problem: loss, gain, \_\_\_\_\_
 Activity level: lethargy, hyperactive, \_\_\_\_\_
 Change in thirst: increased, decreased, \_\_\_\_\_

OTHER \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Client Initials: \_\_\_\_\_