

**Pet Health History**

Pet's Name \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_

Age or DOB \_\_\_\_\_ Breed of Pet \_\_\_\_\_ Color \_\_\_\_\_

Sex:  M  F Has this pet been spayed or neutered?  Yes  No If yes, when? \_\_\_\_\_

When did your pet receive his/her last vaccinations? \_\_\_\_\_

Is your pet currently on heartworm prevention?  Yes  No What kind? \_\_\_\_\_

Is your pet indoor, outdoor or both? \_\_\_\_\_

What health problems, if any, is your pet currently taking medications for? \_\_\_\_\_

\_\_\_\_\_

List your pet's current medications \_\_\_\_\_

Describe your pet's diet \_\_\_\_\_

Please check any symptoms or problems you have noticed with your pet:

- |  |  |                                     |  |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Gagging       | <input type="checkbox"/> Sneezing   | <input type="checkbox"/> Behavioral Changes    |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Excess Thirst | <input type="checkbox"/> Coughing   | <input type="checkbox"/> Increase in Urination |
| <input type="checkbox"/> Vomiting      | <input type="checkbox"/> Limping       | <input type="checkbox"/> Weakness   | <input type="checkbox"/> Breathing Problems    |
| <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Scooting      | <input type="checkbox"/> Scratching | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Shaking Head  | <input type="checkbox"/> Eye Problems  | <input type="checkbox"/> Pain       | <input type="checkbox"/> Swelling              |
| <input type="checkbox"/> Other _____   |  |                                     |  |

Pet's History (please check all that your pet has had):

- Prior Surgery (please list) \_\_\_\_\_
- Prior Illness (please list) \_\_\_\_\_
- Treatment for heartworm infestation (not preventative)
- Dental cleaning

Name & Address of Previous Veterinarian \_\_\_\_\_

How long have you had this pet? \_\_\_\_\_