



Owner Name: \_\_\_\_\_ Pet Name: \_\_\_\_\_

Best Contact Phone #: \_\_\_\_\_ Best method of contact: Phone Call / Text

Reason for visit today: \_\_\_\_\_

Current Medications (please include when last dose was given):  
\_\_\_\_\_

Current Diet: \_\_\_\_\_ Amount fed per day: \_\_\_\_\_

Current Appetite:  normal  increased  decreased

Water Consumption:  normal  increased  decreased

### Recent Medical History

(Please Circle Yes or No & Describe)

Recent injury, accident, or surgery? Yes / No \_\_\_\_\_

Allergic to any medications? Yes / No \_\_\_\_\_

Vomiting? Yes / No How often? \_\_\_\_\_

Diarrhea? Yes / No Consistency? \_\_\_\_\_

Urinating more or less than usual? Yes / No \_\_\_\_\_

Limping? Yes / No Which leg & for how long? \_\_\_\_\_

Coughing, Sneezing, or Gagging? Yes / No How long? \_\_\_\_\_

Skin Problems? Yes / No \_\_\_\_\_

Any lumps or bumps on pets body? Yes / No Location: \_\_\_\_\_

Weight Loss or Gain? Yes / No \_\_\_\_\_

Any behavioral changes? Yes / No \_\_\_\_\_

Heartworm Preventative? Yes / No What kind? \_\_\_\_\_

Flea / Tick Preventative? Yes / No What kind? \_\_\_\_\_

Anything else we should know?  
\_\_\_\_\_

I authorize the following diagnostic tests:

Bloodwork  X rays  Needle biopsy/ cytology  Urinalysis/ Cytology

\* After the doctor has examined your pet, we will be happy to make a treatment plan for you before procedures are performed.

Your pet will be seen on a priority basis. This will be based on the nature of the problem and the time your pet was dropped off with us today.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_