Canine & Feline Patient History Form

Date__________________

Client Information

Patient Name__________________________________________________Patient ID _____
Owner Name__________________________________________________________________________

Diet and Environment

What food does patient currently eat? ___________________________ Amount & Frequency? ______________
Does patient consume treats? Yes/No What kinds? __________________________
Is patient on any dietary supplements? Yes/No If so, what kind and what dosage? __________________________
Does patient consume table food? Yes/No Please explain. __________________________
Is patient primarily indoor or outdoor? __________________________
Are there any other animals in the household? Yes/No If so, are any of them sick? __________________________
Do you board your pet? Yes/No If so, how often? __________________________
Do you have your pet groomed or bathed outside of your home? Yes/No If so, how often? __________________________

Review of Signs

Has patient exhibited any attitude or behavior change? Yes/No Please explain. __________________________
Has patient ever had seizures? Yes/No Please explain. __________________________
Any recent appetite changes? Yes/No Please explain. __________________________
Does patient have any exercise intolerance? Yes/No Please explain. __________________________
Has patient had a decrease in urination? Yes/No Please explain. __________________________
Any recent weight changes? Yes/No Please explain. __________________________
Has patient been vomiting? Yes/No Please explain. __________________________
Has patient had any diarrhea? Yes/No Please explain. __________________________
Has patient been coughing? Yes/No Please explain. __________________________
Has patient been sneezing? Yes/No Please explain. __________________________
Has patient exhibited any signs of lameness? Yes/No Please explain. __________________________
Does patient have difficulty rising after lying down? Yes/No Please explain. __________________________
Has patient been itching? Yes/No Please explain. __________________________
Has patient had any recent hair loss? Yes/No Please explain. __________________________
Does patient have any growths on body? Yes/No Please explain. __________________________
Does patient have any discharge from nose, eyes, vulva, etc.? Yes/No Please explain. __________________________
Has patient had any change in sleep patterns? Yes/No Please explain. __________________________

Reason for Visit (For Sick Patients)

When did the problem start or how long has the problem been occurring? __________________________
__________________________________________________________________________________________________________

(Over →)
What were the first signs of the problem and how did it progress? 

Was patient seen by another doctor for this problem? Yes/No If so, when? 

Were any treatments given by you or another doctor? Yes/No If so, what and at what dosage? 

PAST HISTORY (FOR NEW PATIENTS)
How long have you had the patient? If you acquired patient recently, from where? 

Has patient traveled recently to or from New Jersey (within 6 months)? Yes/No If so, where and when? 

Has your patient been microchipped? Yes/No If so, has the microchip been registered? 

Is patient on flea prevention? Yes/No If so, what type and how often? 

Is patient on heartworm prevention? Yes/No If so, what type and how often? 

Has patient been tested for heartworms? Yes/No If so, when? 

Has the patient been exposed to ticks? Yes/No Please explain. 

Is patient used for hunting? Yes/No Is patient taken camping or on outdoor trips? Yes/No 

Is patient used for breeding? Yes/No If so, is she pregnant or is he currently standing? Yes/No 

Has patient had any prior illnesses, accidents, or surgeries? Yes/No Please explain. 

Is patient aggressive or fearful around strangers? Yes/No Please explain. 

Aside from heartworms, flea & tick preventatives, is patient given any other medication? Yes/No Please explain. 

Does patient have any known allergies to any medications? Yes/No If yes, please list: 

Has patient ever had a reaction to any vaccines? Yes/No If yes, please list and explain below: 

 Owners Signature ____________________________ Date ____________________________