Comprehensive Pet History

Pet: _____ Owner: _____ Date ___/___/___

Are your address & phone number still correct? □ no □ yes
If this is your first visit, is this your first pet? □ no □ yes
Are you aware that pet insurance is available? □ no □ no, tell me more □ yes
Has your pet been microchipped? □ no □ no, but I am interested □ yes
Are you planning on boarding or grooming your pet within the next 6 months? □ no □ yes

Reason for today's visit? □ Annual wellness exam & vaccines □ other _____
Has your pet been seen for the same condition recently? □ no □ yes when _____

Are your pet's vaccinations up to date? □ no □ yes □ don't know
Is your pet spayed or neutered? □ no □ yes □ don't know
Has your pet's stool been checked for parasites within the last 6 months? □ no □ yes □ don't know
Have you seen any worms in your pet's stool? □ no □ yes, describe _____
Is your pet on heartworm prevention? □ no □ yes, year round □ yes, part of the year
What product(s) do you use? _____
What day of the month do you give the heartworm prevention? _____
Is your pet on flea prevention? □ no □ yes, year round □ yes, part of the year
What product(s) do you use? _____
Has your pet had any illness or injury within the last 30 days? □ no □ yes, describe _____
_____
Is your pet currently on any medications? □ no □ yes, list _____
Any known allergies to drugs/medications? □ no □ yes, list _____

What dental care do you provide at home? _____
How often? _____
What do you feed your pet? (list brand and amount) _____
What treats do you feed your pet? _____
What table scraps do you feed your pet? _____
Does your pet have any food intolerances? □ no □ yes, describe _____
Did your pet eat this morning? □ no □ yes

Appetite:	□ decreased	□ normal	□ increased	
Weight:	□ loss	□ stable	□ gain	
Water consumption:	□ decreased	□ normal	□ increased	
Bowel movements:	□ constipated	□ normal	□ diarrhea	
Urinations:	□ decreased	□ normal	□ increased amount	□ increased frequency
	□ straining	□ incontinence (loss of housetraining)		
Vomiting:	□ no	□ yes		
Coughing:	□ no	□ yes		
Excessive panting:	□ no	□ yes		
Difficulty breathing:	□ no	□ yes		
Sneezing:	□ no	□ yes		
Gagging:	□ no	□ yes		
Listlessness/lethargy:	□ no	□ yes		
Weakness:	□ no	□ yes		
Shaking head:	□ no	□ yes		
Scratching:	□ no	□ yes, location _____		

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Significant hair loss:	□ no	□ patchy loss □ generalized loss □ excessive shedding
Scooting:	□ no	□ yes
Bad breath:	□ no	□ yes
Lumps or bumps:	□ no	□ yes, describe location _____
Unusual discharge:	□ no	□ yes, describe location _____
Lameness:	□ no	□ yes Which leg: □ RF □ RR □ LF □ LR
Difficulty rising:	□ no	□ yes
Difficulty climbing stairs:	□ no	□ yes
Stiffness :	□ no	□ yes
Behavioral changes:	□ no	□ yes, describe _____

Is your pet having any other problems or issues that you would like to discuss with the doctor today?

_____