Patient History

Owner Last Name:_____

Pet Name:_____

1. Does your pet have any pre-existing medical conditions? Please check any that apply.

____ Seizures ____ Heartworm disease ____ Dental disease

____ Thyroid disease ____ Allergies ____ Heart murmur

____ Other (please describe) _____

2a. Within the last two weeks, have you observed your pet doing any of the following (please circle)? Coughing Sneezing Nasal discharge/snotty nose Vomiting Diarrhea

2b. If so, has your pet been treated with anything for these conditions? _____

_____

3. Aside from heartworm, flea and tick medications, please list any medications or supplements that your pet currently receives (ex: medications for arthritis or allergies):

_____

_____

4a. Have your pet ever had an adverse reaction to vaccines or a type of medication?

No Yes

4b. If yes, please explain: _____

5. Is there anything else we should know about your pet's health to take better care of him/her today? _____

_____