Patient History

Owner last name: ______________________

Pet name: _________________________

1. Does your pet have any pre-existing medical conditions?

   __Seizures __Heartworm disease __Dental disease

   __ Thyroid Disease __Allergies __Heart Murmur

   ___Other (please describe)___________________________________

2. a. 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?

   b. 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 receives (ex: medications for arthritis or allergies):

   ____

   ____

4. a. Has your pet ever had an adverse reaction to vaccines or a medication?

   No Yes

   4b. If yes, please explain:_____________________________________

5. To your knowledge, has your pet bitten a person in the last 10 days? Yes / No

6. Is there anything else we should know about your pets health to take better care of him/her today?____

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