PATIENT HISTORY QUESTIONNAIRE

Patient Name : _____ Date : _____

Any changes to address and phone number? Corrections _____

Can we add/verify your email address for reminders and bulletins? If yes: _____

What is your preferred method of payment for today's visit? Cash ☐ Check ☐ Debit Card ☐ Credit Card ☐

1. Is your pet currently on any medications? Heartworm Prevention _____ Flea/Tick Control _____
   Other _____
2. Is your pet allergic to any drugs/medication? No ☐ Yes (list) _____
3. Do you need any refills or diet pickups today? No ☐ Yes (list) _____
4. What is your pet's diet? Wet ☐ Dry ☐ Brand _____How much and when each day?_____
5. What percentage of time do you estimate your pet spends outdoors? ____ %
6. Any injury or illness in the past 30 days? No ☐ Yes _____
   _____
7. Any history of seizures? No ☐ Yes (frequency)_____
8. Any recent changes in?

Appetite	No ☐	Yes _____	Bowel Movemts	No ☐	Yes _____
Water Intake	No ☐	Yes _____	Urination	No ☐	Yes _____
Weight	No ☐	Yes _____	Behavior	No ☐	Yes _____

9. Has your pet exhibited any of the following problems?

Lumps/Bumps	No ☐	Yes _____	Shaking Head	No ☐	Yes _____
Hair Loss	No ☐	Yes _____	Bad Breath	No ☐	Yes _____
Scratching	No ☐	Yes _____	Weakness	No ☐	Yes _____
Coughing	No ☐	Yes _____	Lameness	No ☐	Yes _____
Sneezing	No ☐	Yes _____	Stiffness	No ☐	Yes _____
Vomiting	No ☐	Yes _____	Difficulty Rising	No ☐	Yes _____

10. Do you have any other questions or concerns? _____
    _____
    _____
    _____

Technician Notes:

Diagnostic Bloodwork	Reviewed ___	Accepted ___ or Declined ___	Note: _____
Fecal Test	Reviewed ___	Accepted ___ or Declined ___	Note: _____
Urinalysis	Reviewed ___	Accepted ___ or Declined ___	Note: _____
Heartworm Prevention	Reviewed ___	Accepted ___ or Declined ___	Note: _____
Flea/Tick Control	Reviewed ___	Accepted ___ or Declined ___	Note: _____