



PATIENT HEALTH HISTORY FORM

Client: _____ Date: _____

An important part of the medical evaluation is an accurate history. Please take a few moments to complete this questionnaire. Please fill out 1 form for each pet that will be having an exam today. Do your best to answer all of the questions you can. The more information that we have, the better care we can provide for your pet. Additional information may be requested during consultation by the veterinarian.

Patient Name: _____ **Species:** Dog / Cat / _____ **Sex:** M F **Spayed/neutered?** Yes No

Age: _____ **Date of Birth** (if known): _____ **Breed:** _____ **Color/**

Markings _____ **Microchipped?** No Yes, # _____

What is the primary reason(s) you are seeking veterinary medical attention for your pet today? _____

Vaccinations:

Has your pet ever been vaccinated? No Yes; If yes, please provide/attach vaccine records.

Date of Last Rabies Vaccine: _____

Environment:

My pet is exclusively indoor exclusively outdoor both indoor + outdoor

Do you take your pet camping/hiking/fishing/boating/groomer/dog parks? Yes No

Are there other pets in the house? No Yes (list species and age) _____

Are there young children present in the house? Yes No

Has your pet previously travelled? No Yes (describe) _____

Flea/Tick/Heartworm/Deworming

Is your pet on flea/tick preventive? No Yes (brand?) _____

If yes, last dose given? _____

Is your pet on heartworm preventive? No Yes (brand?) _____

If yes, last dose given? _____

When was the last time your pet was dewormed? Never _____

If dewormed - what product was used?: _____

Last heartworm test? Never _____ Was it negative? Yes No

For cats, has your cat ever had a leukemia/FIV test? No Yes, when? _____ Was it negative? Yes No

Grooming

When is the last time your pet was groomed? _____

What grooming facility do you frequent (if any)? _____

How often does your pet get a bath? _____

Dental

Do you brush your pet's teeth? No Yes; if yes, when? _____

Do you use dental products? No Yes; if yes, what brand? _____

Does your pet: suffer from bad breath drop food/drool experience difficulty eating chews on one side

Food:

Your pet's diet is predominately dry food wet/canned food human food combination

What brand of food? _____

What supplements/treats do you give your pet: _____

Does your pet get table scraps? Yes No

How often does your pet get treats once per day multiple times per day weekly monthly

Recently has your pet's appetite decreased increased stayed the same

What about your pet's water consumption? decreased increased stayed the same

When did your pet last eat? _____ Was it a normal amount? No Yes

Is there anything else we should know about your pet's diet? _____

Medications

Is your pet on any medications? No Yes; if yes please list them and the last time your pet has received a dose _____

Does your pet have any known allergies? _____

Has your pet ever experienced an adverse event or allergic reaction to Vaccines, medications and/or sedation/ anesthesia? No

Yes; please elaborate _____

Labwork

Date of last bloodwork _____ My pet has never had bloodwork done

Date of last radiograph/x-ray _____ My pet has never had a x-ray

Date of last fecal analysis _____ My pet has never had a fecal analysis

Date of last urinalysis _____ My pet has never had an urinalysis

Last veterinary visit

This is my pet's first visit to a veterinary hospital/facility

This hospital

Another hospital. Please write the hospital/date/doctor/diagnosis and attach medical records.

Please check any signs/symptoms you have noticed recently about your pet:

- | | |
|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Lack of appetite |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Limping/stiffness |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Lumps/bumps |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching, score? _____ (1 to 10, 10 being really bad) |
| <input type="checkbox"/> Ear Issues | <input type="checkbox"/> Seems depressed |
| <input type="checkbox"/> Eye Discharge/Swelling | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eyes bulging/bloodshot | <input type="checkbox"/> Shaking head |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Spraying house/yard |
| <input type="checkbox"/> Fleas/ticks | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Increased thirst | <input type="checkbox"/> Weight problems <input type="checkbox"/> increased <input type="checkbox"/> decreased |
| <input type="checkbox"/> Increased urination | <input type="checkbox"/> Other |

Has your pet ever had a history of injury, trauma, or been diagnosed with a medical illness? No Yes, elaborate:

Temperament:

Describe your pet's normal temperament? _____

How and where does your pet travel in the car? (carrier/seatbelt/loose/box/etc.) _____

Do you use any anxiety supplements/medications? No Yes; elaborate _____

My pet prefers female veterinary staff male veterinary staff no preference/unknown

Has your pet ever exhibited aggressive tendencies towards other pets? No Yes

Has your pet ever exhibited aggressive tendencies towards people? No Yes

How would you describe your pet around other animals and people? _____

Does your pet have any sensitive areas that s/he does not like to have touched by you or others? _____

Are there any procedures that you have been told seem difficult to perform on your pet? (nail trims, weight, temperature, ear exam, blood draw, etc.) and elaborate on how your pet reacted _____

What is your pet's favorite toy(s); if any: _____

Check any situations below that your pet has shown avoidance or dislike of in the past.

- | | |
|--|---|
| <input type="checkbox"/> entering the vet hospital | <input type="checkbox"/> going into the exam room |
| <input type="checkbox"/> other pets/people passing by in reception/lobby | <input type="checkbox"/> going into the treatment area |
| <input type="checkbox"/> waiting with other pets/people in reception/lobby | <input type="checkbox"/> sounds coming from the treatment area |
| <input type="checkbox"/> being approached by veterinary staff | <input type="checkbox"/> sounds of a clipper/shaver/trimmer |
| <input type="checkbox"/> getting on the scale for a weight | <input type="checkbox"/> being put up on an table for examination |
| <input type="checkbox"/> hearing the doorbell/intercom/phones ringing | <input type="checkbox"/> direct eye contact with veterinary personnel |
| <input type="checkbox"/> loud voices during examination | <input type="checkbox"/> having a rectal temperature taken |
| <input type="checkbox"/> use of a stethoscope | <input type="checkbox"/> use of otoscope (tool to look in ears) |

Anything else we need to know about your pet? _____

Fear Free Questions

Does your pet show any reluctance to getting in the carrier or car?

- Yes
- No

How would you describe your pet's behavior during travel?

- Eager & excited
- Subdued
- More quiet than usual
- More vocal than usual

Does your pet do any of the following during travel?

- Pant
- Tremble
- Pace
- Hide
- Drool
- Vomit
- Poop
- Pee

Are there any situations that your pet has tried to avoid or seemed to dislike in the past? (Select all that apply)

- Entering the veterinary hospital
- Unfamiliar people and/or animals
- Getting onto the scale
- Going into the exam room
- Being put up on an exam table
- Being picked up or carried
- Being removed from a carrier
- Having a rectal temperature taken
- Ear exam/cleaning
- Placement of the stethoscope on the chest
- Nail trim
- Other