

PET HISTORY FORM

Pet Name: _____

Last Name: _____

Date: _____

Is your pet current on all vaccination? Yes No

Is your pet spayed or neutered? Yes No

Is your pet on heartworm prevention? Yes No

Type: Heartgard Sentinel Revolution

Other: _____

What type of flea control do you use on your pet?

Frontline Advantage Sentinel

Other: _____

Has your pet been passing worms? Yes No

Description of worms _____

Any injury or illness in the past 30 days? Yes No

Describe: _____

Does your pet have a history of having seizures?

Yes No

Is your pet currently on any medications? Yes No

If so, medication name and dosage:

Is your pet allergic to any medications/drugs?

Yes No If so, what kind?

What food is your pet currently eating?

Are there any food intolerances/allergies? Yes No

If so, what? _____

Has your pet had any of the following symptoms in the past 30 days?

Vomiting? Yes No Sneezing? Yes No

Coughing? Yes No Lethargic? Yes No

Gagging? Yes No Weakness? Yes No

Shaking head? Yes No Scratching? Yes No

Any hair loss? Yes No If yes:
Patchy Generalized Excessive Shedding

Is your pet scooting? Yes No

In the past 30 days, how is your pet's appetite?

Normal Increased Decreased

In the past 30 days, have you noticed any of the following with your pet's weight?

Stable Losing Gaining

Have you noticed a change in water consumption?

Normal Increased Decreased

Have your pet's bowel movements been

Normal? Diarrhea? Constipated?

Is your pet's urination Normal? Increased frequency

Increased amount?

Is your pet straining to urinate? Yes No

Does your pet have any lumps or bumps? Yes No

Location of lumps: _____

Does your pet have bad breath? Yes No

Have you noticed any of the following in your pet?

Lameness or stiffness? Yes No

Which leg? _____

Difficulty rising: After sitting? Yes No

After sleeping? Yes No After exercise? Yes No

Have you noticed any behavioral changes in the last 30 days? Yes No

Describe these changes:

Do you have any other concerns?
