

# Client History



**Client first & last name** \_\_\_\_\_

**Pets name** \_\_\_\_\_

How long have you owned your pet? \_\_\_\_\_

Where did you obtain your pet? \_\_\_\_\_

Did your pet have any major problems as a puppy or kitten? \_\_\_\_\_

When was s/he last vaccinated? \_\_\_\_\_

Which vaccines were included? \_\_\_\_\_

Does your pet take heartworm prevention?  Yes  No Which one? \_\_\_\_\_

Does your pet receive flea or tick control?  Yes  No Which one? \_\_\_\_\_

Do you have other pets?  Yes  No What types? \_\_\_\_\_

What does your pet routinely eat? \_\_\_\_\_

Do you provide any treats or snacks?  Yes  No What type? \_\_\_\_\_

Does your pet live?  Indoors  Outdoors  Both

Has your pet traveled?  Yes  No If yes, where? \_\_\_\_\_

Has your pet been spayed or neutered?  Yes  No If yes, when? \_\_\_\_\_

If a female, did she have a heat cycle prior to her spay?  Yes  No

Has your pet ever had surgery?  Yes  No If yes, what for? \_\_\_\_\_

Has your pet ever been hospitalized?  Yes  No If yes, what for? \_\_\_\_\_

Has your pet experienced any adverse reactions to foods or medications?  Yes  No \_\_\_\_\_

Are you able to give your pet liquid medications?  Yes  No Pills?  Yes  No

When did your pet last seem normal to you? \_\_\_\_\_

What was the first abnormality you noted? \_\_\_\_\_

What medications is your pet currently taking? \_\_\_\_\_

What medications has your pet taken in the past? \_\_\_\_\_

Please note if your pet has experienced any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Cough                 | <input type="checkbox"/> Sneeze               |
| <input type="checkbox"/> Difficulty Breathing  | <input type="checkbox"/> Fast Breathing       |
| <input type="checkbox"/> Ocular Discharge      | <input type="checkbox"/> Nasal Discharge      |
| <input type="checkbox"/> Increased Appetite    | <input type="checkbox"/> Decreased Appetite   |
| <input type="checkbox"/> Weight Gain           | <input type="checkbox"/> Weight Loss          |
| <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Change in Stool Color | <input type="checkbox"/> Pain Anywhere        |
| <input type="checkbox"/> Lameness              | <input type="checkbox"/> Change in Activity   |
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Fainting             |
| <input type="checkbox"/> Confusion             | <input type="checkbox"/> Change in Behavior   |
| <input type="checkbox"/> Itching               | <input type="checkbox"/> Loss of Hair         |
| <input type="checkbox"/> Bruising              | <input type="checkbox"/> Change in Skin Color |
| <input type="checkbox"/> Any Masses            |   |

List for Additional Medications if Needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_