Date:_____

Dog/Cat medical history form

Owner:_____ **Pet:**_____

Phone Number we can best reach you in parking lot:_____

Reason for visit: Routine (annual) [ ] , Injury [ ] , Illness [ ],
Other:_____

1. **Is your pet eating and drinking normal:** [ ] No [ ] Yes
2. **Is your pet urinating and defecating normal:** [ ] No [ ] Yes
3. **What do you feed your pet, how much and how often:**_____
4. **Is your pet on flea/tick control:** [ ] No [ ] Yes (what kind and how often given and date of last dose:_____)
5. **Is your pet on heartworm prevention:** [ ] No [ ] Yes (what kind and how often given and date of last dose:_____)
6. **Is you pet indoor only:** [ ] No [ ] Yes
7. **Is your pet currently on any medications or supplements?**
   (please list name of medication, dose, and when last given:
   _____
   _____
   _____
   _____
8. **Please check of any of the following symptoms that relate to your pet**

Coughing	Sneezing	Vomiting
Diarrhea	Eye Discharge	Nose Discharge
Lethargy	Lack of appetite	Increase in urinations
Increase in water intake	Straining to urinate	Straining to defecate
Blood in any bodily fluids	Weight Loss	Changes in Attitude
Itching	Licking feet	Skin issues
Limping	Wounds	Lumps/ Masses
Other		

If you checked off any of the above please describe why:_____
_____
_____
_____
_____
_____
_____

Do you have any other questions or concerns you wish to address with the doctor:
_____
_____
_____
_____
_____
_____
_____