

Patient History



Pet's name: _____ Last name: _____

Date: _____ Time: _____

Problem/complaint: _____

When did this problem start? _____

Does your pet have any previous or ongoing medical issues? _____

Is your pet on any medications? yes no
Type/amount/frequency: _____

Travel history: _____

Is your pet housed: indoors outdoors both Neighborhood access? yes no

Has your pet had access to raw fish? yes no Access to garbage? yes no

Access to table scraps or meat bones? yes no If yes please specify: _____

What kind of food does your pet eat? _____

The following questions are based on the last 24-48 hours. Please circle all that apply:

Energy level: low moderate high
Appetite: low moderate high

Has your pet had any access to toxins? yes no When? _____
Type/amount: _____

Is your pet vomiting? yes no Onset: _____
How often, how much and content: _____

Has your pet defecated? yes no When was the last normal stool? _____
Has your pet had diarrhea? yes no Is your pet straining? yes no

Does your pet have a prior history of urinary problems? yes no
Is your pet straining to urinate? yes no

Is your pet coughing or sneezing? yes no Onset: _____
Describe: _____

Are your pet's vaccinations current? _____
Has your cat been tested for FeLV/FIV? yes no Result: _____

Is your pet spayed or neutered? yes no Date of last heat (if applicable): _____
Is your pet pregnant (if applicable)? yes no