

We Welcome Your Pet To Our Clinic!

Client Information

Date: _____

Name _____

Address: _____

Home Phone: () _____ Work Phone: () _____

Number of pets (please specify by type): _____

How did you learn about our clinic?

Friend/Relative _____ (Please include name so that we may thank them)

Phone Book Sign/Location Other _____

Primary reason for visit: _____

Pet Information

Pet's Name: _____ Dog Cat Other _____

Sex M F Age: _____ Birthdate: _____ Breed: _____

Neutered/Spayed: Yes No At what age? _____

What age what the pet obtained? _____

Describe your pet's diet: _____

Is your pet currently on any medications including aspirin or nutritional supplements?

Yes No Comment: _____

Is your pet allergic to any medications or vaccinations?

Yes No Comment: _____

Pet History (Please check all that pet has received in the past 12 months)

- | | | |
|-----------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Distemper | <input type="checkbox"/> Rabies | <input type="checkbox"/> Bordetella (dog) |
| <input type="checkbox"/> Lyme (dog) | <input type="checkbox"/> Fecal | <input type="checkbox"/> Heartworm Test (dog) |
| <input type="checkbox"/> Feline Leukemia/Feline Immunodeficiency Virus Test (cat) | | |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Heartworm preventative | |
| <input type="checkbox"/> Flea & Tick preventative | | |

Has your pet had any routine blood tests, other than heartworm or Feline Leukemia test in the past 60 days? Yes No If so, what, where and when? _____

Please check any symptoms or problems you've noticed with your pet:

- | | | |
|----------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Gums Bleeding | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Coughing | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Increased urination | <input type="checkbox"/> Scooting | <input type="checkbox"/> Unusual Lumps |
| <input type="checkbox"/> Increased thirst | <input type="checkbox"/> Scratching | <input type="checkbox"/> Shaking Head |
| | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Toileting Issues |
| | <input type="checkbox"/> Other _____ | |