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MEDICAL HISTORY/RISK ASSESSMENT

Date: Dr:

This form is intended to help bring to mind conditions or symptoms you may not have noticed or thought important. Your answers help our doctors determine the best treatment plan for your pet. Thank you.

Pet's Name: ______________________________ Owner's Name: ____________________________________

Reason for visit/concern: ____

Please list all medications/supplements your pet is currently taking: ____

What parasite control medication do you use (Sentinel Spectrum, Bravecto, Revolution, etc.)? _______________________

____

Do you ever give your pet any over the counter pain reliever (i.e. Aspirin, Tylenol, Advil, Aleve, etc.)?_________________

What brand of food do you feed your pet? ____________________ How much? ____________ How often? _____________

What protein is in your pet's food (i.e. chicken, fish, beef, lamb, etc.): ____

Is your pet's diet grain free? Yes No

Has your pet been diagnosed with a heart condition or have a history of seizures? ________________________________

Please list any other pets in your household or animals on your property:

Dog(s): Name(s): _____________________________ Breed(s): _____________________

Cat(s): Name(s): ____________________________ Breed(s): _____________________Other: ______________________

(Check if applicable)

Mouth: Bad Breath Loose/Missing teeth Difficulty Eating/Chewing Red/Swollen gums

Yellow/Brown crust on gumline Decreased appetite Weight loss Other: ________________________________

Eyes: No problems Vision Loss Cloudy Drainage Rubbing Other: ________________________________

Ears: No problems Shaking Head Scratching Odor Seems Painful Hearing Loss

Other: ___________________

Skin: No Problems Scratching Rash Bumps/Lumps Hair Loss Other: _______________________________

Appetite: Normal Decreased Increased (describe) ____

Water Intake: Normal Decreased Increased (describe) ____

Urination: Normal Decreased Increased (describe) ____

Activity: Normal Decreased Increased (describe) ____

Mobility: Normal Decreased ncreased (describe) ____

Coughing: No Yes Frequency ____

Sneezing: No Yes Frequency ____

Vomiting: No Yes Frequency ____

Diarrhea: No Yes Frequency ____

Itching: No Yes Frequency ____

Scooting: No Yes Frequency __________________

Does your pet need an Anal Gland Expression today? (additional fee applies): Yes No

Behavior: Normal Abnormal (describe) ____

Pain Level: 0 1 2 3 4 5 6 7 8 9 (most painful) ____ Where? ____

Vaccination Status: Current Needed

Previous problems/treatments/surgery: ____

Does your pet: Go outdoors? Go to the park/trail? Board/Get groomed? Travel with you out of the area?

Prescription Refills/Diets needed today: ____

Would you like a nail trim today (additional fee applies): Yes No

Is your pet microchipped: Yes No Unsure

DOCTORS NOTES (PLEASE DO NOT WRITE BELOW LINE)

Wt: _____________ Temp: ____________

PE: ____

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Diagnostics: ____

TX: ____

RX: ____

PLAN: ____

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