



WELCOME

Whether you are new to our hospital or have been here previously with another pet, we want you to know that **you are a very important part of your pet's health care team.** The information you know about your pet is vital to our doctors being able to identify health problems and/or prevent health problems in your pet. Your help in answering the following questions (even though we may have your pet's previous medical record) will begin our process of taking a complete history. If there is a question that you do not know the answer to, just leave it blank. If you have just acquired your pet, you may not be able to answer many of the questions. The doctor and his/her nurse will ask follow-up questions once you are in the exam room. Just as we need to ask you questions, we want you to always feel free to ask any of us questions concerning any aspect of your pet's care. THANK YOU!

How is your pet feeling about being here? (Please circle)

Happy / A little worried / Very worried / Extremely worried

What can we do to make your pet feel better about today's visit?

No / Yes Is it OK for us to give your pet food rewards (treats)? (please circle)

No / Yes Has your pet ever had an adverse medical reaction to any type of vaccination, medication or anesthetic?

How long has your pet lived with you? _____

Where did you get your pet? (to determine possible recent disease exposure)

Breeder / Private home / Shelter / Pet Store / Stray

Please list other pets in household (type and number, such as, dogs-2, cats-1)

No / Yes Does your pet travel with you or spend time in another city?

What type of food does your pet eat? (Please circle) Dry / Canned / Other

How many times per day do you feed your pet? (Please circle)

Food always available / Once / Twice / Three times / Four times

No / Yes Does your pet receive any vitamins or supplements?

- No / Yes Does your pet have food sensitivities or allergies to anything?
- No / Yes Has your pet been treated for any previous illnesses?
- No / Yes Does your pet go outdoors?
- No / Yes Does your pet ever drink from streams, lakes, or rivers?
- No / Yes Has your pet been spayed or neutered? Age performed _____
- No / Yes Has your pet had any other surgery?
- No / Yes Has your pet had his / her teeth professionally cleaned?
- No / Yes Do you clean your pet's teeth everyday?
- No / Yes Do you give heartworm/parasite preventative to your pet?
Name of medication: _____
Date of last dose: _____

- No / Yes Do you apply flea or tick treatments to your pet?
Name of treatment: _____
Date of last application: _____

Please list all other medications that your pet takes or uses:

Have you noticed? (Please circle)

- No / Yes *a change in appetite?
- No / Yes *fleas or ticks?
- No / Yes *itching or scratching?
- No / Yes *lumps, bumps, non-healing sores, or swellings?
- No / Yes *lameness, difficulty on stairs, or stiffness when rising?
- No / Yes *decreased energy level?
- No / Yes *coughing, sneezing, or difficulty breathing?
- No / Yes *vomiting?
- No / Yes *change in bowel movements (consistency or frequency)?
- No / Yes *increased drinking or increased urination?
- No / Yes *straining to urinate, taking a long time to urinate, accidents in home?
- No / Yes *eye problems (vision, discharge, change in appearance or color of eye)?
- No / Yes *ear problems (head shaking, scratching, odor, discharge)?
- No / Yes *dental problems (bad breath, swelling, tartar, sensitivity)?
- No / Yes *other problems or evidence of pain?
- No / Yes *behavior problems you would like to discuss?

Please keep this questionnaire with you in the waiting room until the Exam Room Nurse comes to escort you and your pet to the exam room.