



Client's Name: _____ Pet's Name: _____ Date: _____

Why is your pet being seen by the Internal Medicine Department? _____

How long has your pet been ill? _____

List any medical problems or procedures that have occurred in your pet's life: (include any surgery, trauma, hospital stays, etc.) _____

General Information:

How long have you owned your pet? _____

What is your pet's diet? Canned Dry Brand: _____ Human Food

Are vaccinations Current? Yes No Which vaccines (if known): _____

Has your pet traveled out of the state in the last six months? Yes No Where? _____

Are there other pets in your household? Yes No Describe: _____

Has your pet been exposed to any of the following? Please check the box if yes and explain:

Ticks Toxins Trauma Foreign Body Fleas

Describe: _____

Current Medications:

Heartworm Prevention: Daily Monthly Heartgard Monthly Interceptor Other

Flea and Tick Prevention: Revolution Frontline Advantage Other

Other Medications in the last 2 months (describe): _____

Any unusual reactions to medications? Yes No: Describe: _____



Changes in Normal Activity:

Appetite: No Increased Decreased Describe: _____

Water Intake: No Increased Decreased Describe: _____

Weight: No Increased Decreased Describe: _____

Urination: No Increased Decreased Straining Blood in urine Unusual odor to urine
Describe: _____

Bowel: No Increased Decreased Diarrhea Constipation
Describe: _____

Vomiting: No Daily Weekly Intermittent Describe: _____

Coughing: No Daily Weekly Intermittent Describe: _____

Sneezing: No Daily Weekly Intermittent Describe: _____

Seizures or convulsions: No Yes Frequency: _____

Changes in walking: No Yes Describe: _____

Skin changes: No Itching Yes Describe: _____

Swelling or Tumors: No Yes Location: _____

Vaginal Discharge: No Yes Describe: _____

Any other changes? (describe) _____

If you wish to make any additional comment please attach a sheet of paper.