



**Owner Information:**

Last name: \_\_\_\_\_ Pet Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Patient Information:**

- Breed: \_\_\_\_\_
- Gender:  Male  Female  Spayed/Neutered
- Age: \_\_\_\_\_
- Are vaccines current? (Provide a copy of vaccine record, if available)  YES  NO

**Define the problem:**

- Presenting concern: \_\_\_\_\_
- How long has the issue been going on? \_\_\_\_\_
- Has the presenting concern improved over time  YES  NO
- How is your pet's appetite and water intake?  Normal  Decreased  Increased
- Please check any additional symptoms that may be present if not the primary concern:  
 Vomiting  Diarrhea  Coughing  Sneezing  
Other: \_\_\_\_\_

**Pain:**

- Does your pet seem painful? If yes, what do you think your pet's level of pain is? (give a score out of 1-10, e.g. a fractured leg is typically 7-10)  
 Yes  No; If yes, please select pain score:  1-3  4-6  7-8  9-10

**Medical History:**

- Does your pet have any previous medical condition(s)? If yes, please list: YES  NO   
\_\_\_\_\_
- Does your pet have any known allergies? If yes, please list: YES  NO   
\_\_\_\_\_
- List any current medication that your pet is taking?  
\_\_\_\_\_
- Is your pet currently on any flea, tick or heartworm preventatives? If yes, please list: YES  NO   
\_\_\_\_\_
- Has your pet been treated elsewhere for any recent illnesses, or undergone any prior surgeries?  
YES  NO 
  - If so, list procedure(s) and do we have permission to call for records?  
(If so, please provide the clinic name.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Procedure(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Clinic name