

Patient History Form

Pet's Name: _____ Dog Cat Other _____

Age/Birthdate (Or Best Guess!): _____ Sex: Male Female Breed: _____ Color: _____

Neutered/Spayed Yes No At what age? _____

Has this pet ever lived in a different state or country? Yes No If yes, where? _____

How did you obtain this pet? Breeder Friend Rescue Stray Pet Shop Other _____

How long have you owned your pet? _____

Where do you keep your pet? Inside Only Indoor/Outdoor Outside Run/Pen Other _____

How much time of your pet's day is spent outside on average? _____

Do you have any other pets? Yes No If yes, what are they? _____

What kind of food does your pet eat? Dry Canned Table Scraps Other _____

Name/Brand of food _____ Any additional treats: _____

Current Medications/Supplements (Including Heartworm/Flea and Tick Prevention): _____

Please list any previous medical conditions your pet has had: _____

What are your current health concerns for your pet? _____

Any additional information or concerns you would like to share with us about your pet? _____
