



Pet Health History

Owner: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Name of Pet: _____ Dog or Cat? Breed: _____ Male or Female?

Neutered or Spayed? Color: _____ Date of Birth/Age: _____ Microchipped: _____

Any Known Allergies: _____

Please (X) any symptoms or problem that you have noticed about your pet:

- | | |
|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Behavior Problems |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Increase in Thirst or Urination |
| <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Scooting |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Shaking Head |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Vision or Hearing Problems |

Other: _____

Reason for Visit: _____

Vaccination History: _____

Date and Type of Last Vaccinations: _____

Last Heartworm Test: _____ Pet's Last Veterinary Visit: _____

Describe Pet's Diet (including treats): _____

List Pet's Current Medications: _____

How did you hear about our clinic? _____

Authorization: I hereby authorize the veterinarians to examine, prescribe for or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand the charges will be paid for at the time of discharge.

Signature of Owner or Agent: _____ Date: _____

We will gladly prepare a written estimate if you desire. Thank you for the opportunity to care for your pet.