Patient History Form

Date: _____/_____/_____

Patient Name: _____ Client Name: _____

Presenting problem: _____

How long has this problem been present? _____

Was the problem: Sudden Onset☐ Slowly Progressive☐ Intermittent☐

Have there been previous occurrences: Yes☐ No☐ If yes, please explain: _____

_____

Has your pet had any respiratory problems, such as coughing, sneezing, nasal discharge, labored breathing, or other symptom: Yes☐ No☐

If yes, please describe the symptom, timing, and frequency: _____

_____

Has your pet had any vomiting: Yes☐ No☐ If yes, please describe the appearance of the vomitus, when and how often it occurs:

_____

Are your pet's stools: Normal☐ Abnormal☐ If abnormal, describe the abnormalities: _____

_____

Have you observed any changes in water intake or urination habits: Yes☐ No☐ If yes, please describe the changes: _____

_____

Is your pet's appetite: Normal☐ Abnormal☐ If abnormal, describe the abnormalities: _____

_____

What is your pet's normal diet? _____

Does your pet have a history of seizures? Yes☐ No☐ If yes, please explain when they occurred, the frequency, and any medications used: _____

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Is your pet's activity level and exercise tolerance: Normal☐ Abnormal☐ If abnormal, describe the abnormalities: _____

_____

Is your pet's gait/movement: Normal☐ Abnormal☐ If abnormal, please describe the abnormalities (for example limping on the right front foot): _____

What level of pain do you think your pet is feeling? None (0)☐ Minimal (1)☐ Mild (2)☐ Moderate (3)☐ Severe (4)☐

Is your pet currently on any medications? Yes☐ No☐ If yes, please list the name, dose and frequency given: _____

_____

Please list your pet's known medication or food allergies: _____

Does your pet travel out of Oregon or have you just moved to this area? Yes☐ No☐ If yes, please explain: _____

_____

Are there any other pets in the household? Yes☐ No☐ If yes, please list them: _____

Is your pet: Indoor Only☐ Outdoor Only☐ Indoor/Outdoor☐

Current vaccinations (check all that apply): Canine Distemper☐ Rabies☐ Leptospirosis☐ Feline Distemper☐ Feline Leukemia☐ Other☐ _____

Please list any other previous major medical problems or trauma: _____

_____

Please do not write below–for hospital use only

Wt (Kg): _____ Temp: _____ HR: _____ Pulse: _____ RR: _____ MMs/CRT: _____

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