## Medical History: Please fill out carefully and completely

Date:_____ Client Name: _____

Patient Name: _____DOB:_____ Gender: Male/Female Spay/Neuter

Species:_____Breed:_____Color: _____
Why did you bring your pet in today? Primary Health Concern:_____
When did the problem start? _____ Is it chronic or intermittent? _____
Has your pet had any other problems in the past? _____

Has your pet had any x-rays or blood work within the last 6 months? Yes/No

### Bones, Muscles and Ligaments:

Is your pet lame? Yes/No Where is the lameness? _____
Is it chronic or intermittent?
_____

Does exercise make your pet better or worse? _____

Does the weather affect your pet? Yes/No Worse with? cold/hot Worse in what season: _____
Do you think your pet is painful? If so, where? _____

Has your pet had surgery or other treatment for lameness or a back problem? Yes/No
If yes, when and where? _____

### Skin Appearance:

Circle all that apply: red / dry / flaky / itchy / greasy / crusty / scabby / oozing / odor / hair loss

Where is the primary location of the skin problem? _____

Are the problems seasonal? Yes/No Is the itching worse during the DAY or NIGHT? _____

Are you using any flea or heartworm control products? Yes/No If yes, what? _____

### Gastrointestinal:

How is your pet's appetite? Good / Fair / Poor / Not at all Energy Level: Good / Fair / Poor / Not at all

Gums/teeth: Does your pet have bad breath? Yes/No Bad teeth? Yes/No Any ulcers? Yes/No

Amount of water intake: Large / Normal / Small / Not Drinking

Is your pet vomiting? Yes/No If so, What? Bile / Fluid / Undigested Food / Grass / Foreign Bodies
When does your pet vomit? Describe: _____
How often? _____

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## **Gastrointestinal** (continued)

Does your pet have any gurgling sounds coming from the abdominal region? Yes/No

Stools: Normal / Diarrhea / Undigested Food / Mucus / Blood / Hard / Soft / Strong Odor / Constipated

Does your pet pant a lot? Yes/No

Urine: Any changes in: Odor / Frequency / Straining
Describe: _____

Is your pet incontinent? Yes/No Any Medications? _____

Has your pet ever had Kidney Stones / Bladder Stones / Crystals / Bladder infections?
If so, when? _____

## **Heart and Lungs**:

Does your pet cough? Yes/No Is it: More at Night / During Exercise / Seasonal?
Is the cough? Hacking / Wheezing / Dry / Moist / Gagging / Frequent / Infrequent / Chronic / Weak

Any history of a heart murmur: Yes/No Since when? _____

Any unusual behavior: Anxiety / Pacing / Howling / Fearful / Confusion
Other problems, please describe: _____

## **Neurologic**:

Seizure Activity: When did the seizures start? _____
How long do they last? _____ How often do they happen? _____

Does your pet lose control of his/her bladder? Yes/No

Is your pet on any medication for the seizures? Yes/No If so, what? _____

## **Eyes**:

Eye Problems? Yes/No Which eye: Right / Left / Both
Discharge? Yes/No Is it: Clear / Green / Yellow / White / Gray Are the eyes red or dry? Yes/No
Are you using any medications? Yes/No What medications? _____

## **Ears**:

Ear problems? Yes/No Which ear: Right / Left / Both
Problems? Shaking Head / Odor / Discharge / Chronic / Acute

## **Nose**:

Any Discharge? Yes/No If so, for how long? _____One or both nostrils? _____

What color is the discharge? _____ Is there Blood / Mucus / Scabbing / Crusting

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## Diet

Daily diet and medications (please be very specific listing brand and ingredients):
Dry food: _____
Canned Food: _____
Raw Food: _____
Home Cooked Food: _____
Snacks/ Treats: _____
How many times a day do you feed your pet? _____

Is your pet on any supplements? Yes/No If so, what kind and how often are you giving them?
Vitamins: _____
Herbals/Nutraceuticals:_____
Essential Fatty Acids: _____

Arthritis medications? Yes/No Please describe dose and strength: _____

Is your pet on any other medications? Yes/No If so, what is the medication, the dosage, and how many times per day? _____
How long has your pet been on these medications? _____
Does your pet have any known ALLERGIES to food, drugs or products? Yes/No What is your pet allergic to?
_____

When was your pet last vaccinated? _____

How often does your pet get exercise? Every Day / Often / Not so often / None
Does your pet spend more time indoors or outdoors? _____

Where did you get your pet? _____When? _____

If you did not bring any records today or have not had them e-mailed or faxed to our office prior to your visit by your previous veterinarian, we kindly ask that you contact your previous veterinary hospital and have the most recent lab work, x-rays, and medical records (from at least the last 2 years) faxed to 515-274-3887 or e-mailed to info@apvet.com. Thank you very much!!

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