Patient Medical History

Please fill out carefully and completely. Thank you!

Client Name: _____

Pet Name: _____ **DOB:** _____

Species: Canine ☐ Feline ☐ **Gender:** Male ☐ Female ☐ Neutered ☐ Spayed ☐

Breed: _____ **Color:** _____

Why did you bring your pet in today? What are your primary health concerns?

_____

When did the problem start? _____

Is it chronic or intermittent? _____

Has your pet had any x-rays or bloodwork done within the last 6 months? Yes ☐ No ☐

If yes, at what veterinary clinic was this done? _____

Bones, Muscles and Ligaments:

Is your pet lame/limping? Yes ☐ No ☐ yes, what limb(s)? _____

Is it chronic or intermittent? _____

Does exercise make you pet better or worse? _____

Does the weather affect your pet? Yes ☐ No ☐ yes, hot or cold, or what season? _____

Do you think your pet is painful? Yes ☐ No ☐ so, where? _____

Has your pet had surgery or other treatment(s) for lameness or spinal issues? Yes ☐ No ☐

If yes, what treatment, when and where? _____

Is your pet on any pain or arthritis medications? Yes ☐ No ☐

If yes, what is the medication (include strength and dose): _____

Skin Appearance:

Does your pet have any skin problems? Please circle all that apply:

red ☐ dry ☐ flaky ☐ itchy ☐ greasy ☐ crusty ☐ scabby ☐ oozing ☐ bleeding ☐ hair loss ☐

Other (Please describe): _____

Where is the primary location of the skin problem? _____

Is the problem seasonal? Yes ☐ No ☐ Is the itching worse during the DAY or at NIGHT? _____

Are you currently using any flea, tick, or heartworm control products? Yes ☐ No ☐

If yes, what product(s)? _____

Does your pet have any (new) lumps or bumps? Yes ☐ No ☐

If yes, where? _____

Have any of the lump(s) changed in size or shape? Yes ☐ No ☐

If yes, please describe: _____

Eyes:

Does your pet have any eye problems? Yes ☐ No ☐ If yes, which eye? Right ☐ Left ☐ Both ☐

Is there any discharge from the eye(s)? Yes ☐ No ☐

If yes, please described what the discharge looks like (color): _____

Are your pet's eyes red or appear dry? Yes ☐ No ☐

Is your pet squinting or holding its eye(s) shut? Yes ☐ No ☐

Does your pet's eye(s) appear cloudy? Yes ☐ No ☐

Are you currently using any eye medication on your pet? Yes ☐ No ☐

If yes, what is the medication? _____

Ears:

Does your pet have any ear problems? Yes ☐ No ☐ If yes, which ear? Right ☐ Left ☐ Both ☐

Is your pet experiencing any of the following? Please circle all that apply.

Shaking head ☐ Scratching ☐ Discharge from ears ☐ Redness in ears ☐ Odor coming from ears ☐

Is this problem: ☐ cute (new/never happened before) ☐ Chronic ☐ Seasonal ? ☐

Are you currently using any ear medication on your pet? Yes ☐ No ☐

If yes, what is the medication? _____

Nose:

Does your pet sneeze frequently? Yes ☐ No ☐

Does your pet have any nasal discharge? Yes ☐ No ☐

If yes, please describe what the discharge looks like (color): _____

How long has your pet had nasal discharge? _____

Is it from one or both nostrils? _____

Is there any of the following? Please circle all that apply.

Blood ☐ Thick mucus ☐ Scabbing ☐ Crusting ☐ Loss of pigment ☐ Scaly or rough skin ☐

Oral and Gastrointestinal:

How is your pet's appetite? Good ☐ Fair ☐ Picky eater ☐ Poor ☐ Not at all ☐

How is your pet's energy level? High energy ☐ Active ☐ Fair ☐ Couch potato ☐ Lethargic ☐

Does your pet have bad breath? Yes ☐ No ☐ Plaque/tartar/stained teeth? Yes ☐ No ☐

Does your pet have any sores or ulcers in or around the mouth? Yes ☐ No ☐

What is your pet's amount of water intake? Large ☐ Normal ☐ Small ☐ Not drinking ☐

Is your pet vomiting? Yes ☐ No ☐ If so, what? Please circle one or more below:

Bile ☐ Liquid or water ☐ Undigested food ☐ Grass ☐ Foreign body (plastic, toy, fabric, etc.) ☐

When does your pet vomit? Please describe: _____

How often is your pet vomiting? _____

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

How are your pet's stools? Please circle all that apply.

Normal ☐ Soft ☐ Diarrhea ☐ Mucus ☐ Bloody ☐ Hard ☐ Strong odor ☐ Constipated ☐

If stools are abnormal, how long has this been going on? _____

Urinary:

Has your pet had any changes in urine: Odor ☐ Frequency ☐ Straining ☐

If yes, please describe: _____

Is your pet experiencing incontinence (leaking or dribbling urine)? Yes ☐ No ☐

Is your pet on any medications or supplements for urinary issues? Yes ☐ No ☐

If yes, what is the medication/supplement? _____

Has your pet ever had any of the following? Please circle all that apply.

Kidney stones ☐ Bladder stones ☐ Crystals in urine ☐ Bladder infection ☐

If yes, when did this issue occur? _____

Heart and Lungs:

Does your pet pant a lot? Yes ☐ No ☐

Does your pet breathe quickly or heavily when resting? Yes ☐ No ☐

Does your pet cough? Yes ☐ No ☐ If yes, when does it primarily occur? Please circle all that apply.

More at night ☐ During exercise or play time ☐ Seasonal (spring or fall?) ☐

What does the cough sound like? Please circle all that apply.

Hacking ☐ Gagging ☐ Wheezing ☐ Dry ☐ Productive ☐ Weak ☐

Is the cough: Intermittent ☐ Frequent ☐ Chronic ☐

Does your pet have a history of a heart murmur? Yes ☐ No ☐

If yes, when was it first noted? _____

Has your pet ever suddenly collapsed? Yes ☐ No ☐

If yes, please describe the event: _____

Neurologic:

Does your pet have trouble walking (stumbling or falling, trouble placing feet, weak or shaking legs?)

Yes ☐ No ☐ If yes, please describe: _____

Does your pet have seizures? Yes ☐ No ☐

If yes, when did the seizures start? _____

How long do the seizures normally last? _____

How often does your pet have seizures? _____

Does your pet lose control of the bladder and/or bowels? _____

Is your pet on any medications to control seizures? Yes ☐ No ☐

If yes, what is the medication? _____

Behavior:

Does your pet experience any of the following? Please circle all that apply.

Anxiety ☐ Pacing ☐ Howling ☐ Fearful ☐ Confusion ☐ Aggression ☐

Other problems (Please describe): _____

When/how often does this occur? _____

Is your pet on any medications or supplements to help with this problem? Yes ☐ No ☐

If yes, what is the medication? _____

Nutrition:

Please list the following foods your pet currently eats. Please be specific, listing brand and flavor, formula and/or ingredients.

Dry food: _____

Raw food: _____

Homemade food: _____

Treats or snacks: _____

If you measure out the food for your pet, how much do you feed per meal? _____

How many times per day do you feed your pet? _____

Is your pet on any supplements? Yes☐ No☐ If yes, please describe below (brand, dose, how often):

Vitamins: _____

Herbals/Nutraceuticals: _____

Essential Fatty Acids (fish oil or omegas): _____

Does your pet have any known allergies to foods, drugs, or products? Yes☐ No☐

If yes, what is your pet allergic to? _____

Wellness:

When was your pet last vaccinated? _____

Where was your pet last vaccinated? _____

How often does your pet get exercise? Every day ☐ Often ☐ Not very often ☐ None ☐

Does your pet spend more time indoors or outdoors? _____

If you did not bring any previous records for your pet today, or have not had them emailed or faxed to our office prior to your visit, we kindly ask that you contact your previous veterinary hospital or persons/facility responsible for your pet's past care. Please have the most recent lab work, x-rays, and medical records (from at least the last 2 years) faxed to 515-274-3887 or emailed to info@apvet.com.

Thank you very much!

SIGNATURE _____ DATE _____

IOWA VETERINARY WELLNESS CENTER
YOUR PET. OUR PASSION.

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