IOWA VETERINARY WELLNESS CENTER
YOUR PET. OUR PASSION.

New Patient Form

Thank you for giving us the opportunity to care for your pet(s). Please help us better meet your needs by taking a moment to complete this information sheet.

Pet Name:	
Species:	
Age/DOB:	
Gender:	
Color:	
Microchip?	

What clinic, if any, has your pet been seen at before?

Prior Illness/Diagnosis:

Prior Surgery:

Current Medication(s):

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Diet: (Please include brand, flavor, amount, and any treats or snacks.)

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

BONES, MUSCLES, AND LIGAMENTS:

Is your pet lame/limping? ☐ Yes ☐ No

If yes, what limb(s) and for how long?

SKIN APPEARENCE:

Does your pet have any skin problems? ☐ Yes ☐ No

If yes, where and for how long?

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 and when did you first notice it/them?

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

EYES:

Does your pet have any eye problems? ☐ Yes ☐ No

If yes, what problems and which eye?

EARS:

Does your pet have any ear problems? ☐ Yes ☐ No

If yes, what problems and which ear?

NOSE:

Does your pet sneeze frequently? ☐ Yes ☐ No

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

If yes, what color?

ORAL AND GASTROINTESTINAL:

Does your pet have any oral issues? (sores, ulcers, scabs, loose teeth, bad breath, etc.) ☐ Yes ☐ No

If yes, what problems? When did you first notice them/have they gotten worse?

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

Is your pet vomiting? ☐ Yes ☐ No

If yes, what is it that's being vomited up? How often?

How are your pets stools? Please check/mark 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, or straining? ☐ Yes ☐ No

If yes, please describe:

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

HEART AND LUNGS:

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

If yes, please describe:

Does your pet cough? ☐ Yes ☐ No

If yes, when during the day does it happen/how often? What does it sound like?

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

If yes, when was it first noted?

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 they normally last, and how often is your pet having them?

BEHAVIOR:

Does your pet experience any of the following? Please check/mark all that apply.

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

If yes, when/how often does this occur?

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

If yes, what is your pet allergic to?

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@iowavetwellness.com.

Thank you very much!

Owner Signature: _____

Thank you so much for choosing Iowa Veterinary Wellness Center as your pet's health care provider. We look forward to developing a relationship with both you and your pet. If there is anything that we can do to improve your experience, please let one of our staff members know.

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