

INITIAL VISIT FORM FOR ALTERNATIVE MEDICINE

Name: _____ Patient: _____

Please contact your primary veterinarian and have all recent medical history faxed to me at 860-704-0344. If possible, please fax this completed form as well.

Please list all medications/supplements and doses:

Please complete the following questionnaire to the best of your knowledge:
(Please check on the line in **front** of the word to be checked.)

Your pet's body condition tends to be: ___ Normal ___ Thin ___ Overweight

Eyes:

Vision: ___ Normal ___ Deficit ___ Blind
Discharge: ___ Clear ___ Mucous ___ Pus ___ Crusty
Amount of discharge: ___ Scant ___ Moderate ___ Profuse
Inflammation: ___ Conjunctiva I ___ Corneal ___ Retinal

Ears:

Hearing: ___ Normal ___ Deficit ___ Deaf
Infection/Inflammation: ___ Itchy ___ Odorous ___ Redness ___ Discharge
___ Mites/Bacteria/Fungus

Nose/Upper Respiratory Tract:

Discharge: ___ Clear ___ Pus ___ Crusty
Amount of discharge: ___ Scant ___ Moderate ___ Profuse
Sneezing: ___ Occasional ___ Frequent

Does your pet: ___ Snore? ___ Have reverse sneezing? ___ Have a history of upper respiratory infection?

Lower Respiratory Tract:

Does your pet have: ___ Fast breathing? ___ Trouble breathing out (exhaling)?
___ Excessive panting? ___ Noise in the chest when breathing? ___ shortness of breath?
Cough: ___ Dry ___ Moist
Is cough productive? ___ Watery ___ Mucous ___ Pus ___ Bloody

Dental:

___ Tartar ___ Dental extractions ___ Ulcers ___ Bleeding gums

Thirst:

___ Normal ___ Reluctant to drink water ___ Increased thirst (Frequent sips)
___ Increased thirst (Tanks up)

Appetite:

___ Normal ___ Increased ___ Decreased ___ Prefers to eat at night
___ Prefers small amounts of food frequently ___ Eats grass ___ Eats dirt/other non-edible things

Name: _____ Patient _____

Nausea/Vomiting:

____ None ____ Rare ____ Frequent ____ Relates to meals (within 1-2 hours) ____ Relates to time of day
Please describe pattern of vomiting: _____
Appearance of vomit: ____ Food ____ Mucous ____ Bile (yellow) ____ Foamy ____ blood
____ Coffee grounds

Stools:

____ Normal ____ Constipation ____ Dry ____ Diarrhea ____ Odorous (strong) ____ Bloody
____ Mucous ____ Watery ____ Oily ____ Times per day

Heart:

____ Normal ____ Heart murmur ____ Cardiomyopathy ____ Arrhythmia ____ Congestive heart failure
____ On medication for heart

Urinary System:

____ Normal ____ URI ____ Uroliths (stones) ____ Chronic renal failure ____ Incontinence
____ Kidney infection ____ Other kidney disease

Reproductive System:

____ Spay/neutered at ____ (age) ____ Used for breeding ____ Number of litters

Endocrine System:

____ Diabetes mellitus ____ Hyperthyroidism ____ Hypothyroidism ____ Hyperadrenocorticism (Cushing's
Disease) ____ Other: _____ Age of onset of problem

Musculoskeletal System:

____ Normal ____ Abnormal
Lameness: ____ Constant ____ Intermittent ____ Age of onset _____ Season of onset _____
Affected limbs/joints: _____
Dysplasia site(s) Hip/Elbow etc): _____
____ Panosteitis ____ Worse in cold ____ More still than painful/worse in damp
____ Severe pain and joint swelling ____ Advanced degenerative joint disease

Neurologic System:

____ Normal ____ Neurologic deficits ____ Epilepsy ____ Age of onset

Integument (skin/hair):

____ Normal
Skin: ____ Dry ____ Moist ____ Oily ____ Inflamed (red) ____ Itchy ____ Body odor
Allergies? Please describe: _____

Diet:

____ Dry food ____ Canned food ____ Home cooking ____ Combination
Brand/type etc: _____

Any History of: (Please explain/describe if possible)

Infections: _____
Neoplasia/Cancer: _____
Other health problems/diagnoses: _____

