Date:_____

MEDICAL HISTORY/RISK ASSESSMENT

This form is intended to help bring to mind conditions or symptoms you may not have noticed or thought important. Your answers help our doctors determine the best treatment plan for your pet. Thank you.

Pet's Name _____ Owner's Name_____ Client ID_____

Reason for Visit/Complaint**:**_____

Please list any Medications/supplements your pet is currently taking**:**_____

(Circle if applicable)

Mouth: Bad Breath Loose/missing teeth Difficulty eating/chewing Decreased appetite
Red/swollen gums Yellow/brown crust on gum line Weight loss

Eyes: No Problems Vision Loss Cloudy Drainage Rubbing Other:_____

Ears: No Problems Shaking Head Scratching Odor Seems Painful Hearing Loss Other:_____

Skin: No Problems Scratching Rash Bumps/Lumps Hair Loss Odor Other:_____

Appetite: Normal Decreased Increased_____

Water Intake: Normal Decreased Increased_____

Urination: Normal Decreased Increased_____

Activity: Normal Decreased Increased_____

Mobility: Normal Decreased Inability to: Stand Jump Up Run Other_____

Coughing: No Yes Frequency_____

Sneezing: No Yes Frequency_____

Vomiting: No Yes Frequency_____

Diarrhea: No Yes Frequency_____

Itching: No Yes Frequency_____

Scooting: No Yes Frequency_____

Behavior: Normal Abnormal (describe)_____

Pain Level 1 2 3 4 5 6 7 8 9 10 (most painful) Where?_____

Previous Problems/Treatments/Surgery:_____

What do you feed your pet?_____ How often?_____ Does your pet stay: Inside Outside Both?

Does your pet: Go to the park/trail? Travel with you out of the area? Board/get groomed?

What Parasite Control medication do you use?_____

Prescription Refills/Diets Needed today:_____

Does your pet have a microchip? Yes No Unsure

Cypress Creek PET CARE
ANIMAL HOSPITAL AND BOARDING FACILITY