

## NEW PATIENT MEDICAL HISTORY

**PET'S NAME:**

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**TYPE:** CAT DOG OTHER BREED:

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**SEX:** FEMALE MALE **SPAYED/NEUTERED:** YES NO

**COLOR:** \_\_\_\_\_ **D.O.B./AGE:** \_\_\_\_\_

**REASON FOR TODAY'S VISIT:**

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**WHAT DO YOU FEED YOUR PET?**

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**DOES YOUR PET LIVE:** INDOORS OUTDOORS OR BOTH

**HEARTWORM PREVENTION:** YES NO

WHAT TYPE? \_\_\_\_\_

**FLEA/TICK CONTROL:** YES NO

WHAT TYPE? \_\_\_\_\_

**IS YOUR PET ON ANY MEDICATIONS?** YES NO

IF YES, TYPE AND DOSE: \_\_\_\_\_

**PREVIOUS HEALTH ISSUES?**

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**ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR PET?**

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**\*\*FOR YOUR PET'S AND OTHERS' SAFETY, PLEASE KEEP YOUR PET RESTRAINED ON LEASH OR IN A CARRIER\*\***

