Patient Appointment Information Form

The following information will be used to help our veterinary team accurately complete your pet's medical history for today's visit.

Today's Date: ___/____/____

Your name: _____ Pet name: _____

If we need to contact you or someone with permission to make medical and financial decisions.
☐ You or ☐ Name_____

1st Phone #_____ 2nd Phone #_____

Concerns you may have for visit today: (check all that apply)

☐ Annual Exam	☐ Lethargic	☐ Bloodwork	☐ Constipation
☐ Eating	☐ Vomiting	☐ Itching/Scratching	☐ Behavioral
☐ Drinking	☐ Diarrhea	☐ Skin Masses/Lesions	☐ Coughing
☐ Bad Breath	☐ Eyes	☐ Scooting	☐ Limping
☐ Weight Loss	☐ Ears	☐ Shaking Head	☐ Painful
☐ Weight Gain	☐ Urination Issues	☐ Gagging	☐ Nail Trim
☐ Check Lump(s)	☐ Deworm	☐ Anal Glands	☐ FIV/FLV Test
☐ Heartworm Test	☐ X-rays	☐ Other _____	

Vaccination

Canine Vaccines		Feline Vaccines	
☐ DHLPP	☐ Bordetella	☐ FVRCP	☐ FeLV
☐ Leptospirosis	☐ Rabies	☐ Rabies	
☐ Canine Influenza			

Please explain your concerns briefly for our team. How long has this issue persisted? Which leg, eye, or ear? Has eating/drinking increased or decreased? Etc.…Any information is helpful to our team.

_____
_____
_____
_____
_____

When did your pet last eat? _____ ☐ am ☐ pm ☐ Today or ☐ Yesterday

Has your pet ever had an adverse reaction to any medications, vaccines or procedure?
☐ Yes ☐ No *If so, describe* _____

Is your pet taking any medications, supplements, prescription food? ☐ Yes ☐ No
If so what are they? _____
Any refills needed? ☐ Yes ☐ No _____

What is the lifestyle of your pet?
☐ Indoor Only ☐ Indoor/Outdoor ☐ Dog Beach ☐ Dog Park ☐ Hike/Swim