

Owner: _____
 Patient: _____
 Date: _____

**If you are dropping off for services a number must be listed and the form completed for us to perform services.
 Services will not be performed if form is not complete.**



Patient History Questionnaire

Any changes in your information (name, address, phone): Yes No

If Drop off/surgery/groom, what is the **best number** to reach you at: _____

Is your pet: Indoor Outdoor Both	Current on Vaccines: Yes No-Updating today
Heartworm Preventative: Interceptor Advantage Multi Other: _____	Flea/Tick: Frontline Plus Advantage Multi Comfortis Other: _____
Do you use any Dental Products: None CET Chews Brush Teeth Oravet Other: _____	Food: WET DRY BOTH Brand: _____ How much: _____ How Often: _____
Any medications (besides flea/heartworm): No Yes Name of Medication: _____ Amt given: _____ How often: _____	Is your pet allergic to any medications? Yes No Medication: _____ React to vaccines? Yes No Vaccinations: _____

Urinating/Defecating normally	Yes	No
Vomiting/ Diarrhea	Yes	No
Hair Loss/Scratching	Yes	No
Lameness/ Stiffness/ Difficulty Rising	Yes	No
Eating/ Drinking normally	Yes	No
Bad Breath	Yes	No
Seizures	Yes	No

Does your pet have any other problems which need to be addressed?

Grooming Appointments additional notes:

Refill requests: Heartworm prevention Flea control Other: _____

Owner's Signature: _____