

Please check all appropriate boxes and/or fill in information and add any information you feel is important.

Current Problem and Medical History

Client's Name: _____ Pet's Name: _____ Date: _____

Why did you bring your pet to the Emergency Department? _____

How long has your pet been ill? _____

List any medical problems or procedures that have occurred within the last two years: (include any surgery, trauma, etc.)

General Information

How long have you owned your pet? _____

What is your pet's diet? Canned Dry Brand: _____ Table Food

Are vaccinations current? Yes No

Has your pet traveled out of state in the last six months? Yes No

Are there other pets in your household? Yes No Describe: _____

Current Medication

Heartworm prevention: Daily Monthly Heartguard Monthly Interceptor

Other medications (describe): _____

Any unusual reaction to medications? Yes No Describe: _____

Changes In Normal Activity

Appetite: No Increased Decreased Describe: _____

Water intake: No Increased Decreased Describe: _____

Weight: No Increased Decreased Describe: _____

Urination: No Increased Decreased Straining Blood in urine Unusual odor to urine

Describe: _____

Bowel habits: No Increased Decreased Describe: _____

Vomiting: No Daily Weekly Intermittent Describe: _____

Coughing: No Daily Weekly Intermittent Describe: _____

Sneezing: No Daily Weekly Intermittent Describe: _____

Seizures or convulsions: No Yes Frequency: _____

Changes in walking: No Yes Describe: _____

Skin changes: No Itching Yes Describe: _____

Swelling or tumors: No Yes Location: _____

Vaginal discharge: No Yes Describe: _____

Any other changes? (describe): _____

If you wish to make any additional comments, please check this box and use the back of this page.