

Healthy Pet History

Pets Name: _____

Date: _____

Common Questions

1	Has your pet received non-vaccine treatments somewhere else in the past 12 months?	YES	NO
2	If so, where? _____ Phone: () - _____		
3	When? _____		
4	Diagnosis? _____		
5	Was the problem resolved?	YES	NO
6	Is your pet intact (not spayed/neutered)? Last heat? _____ (females only)	YES	NO

Feline History Questions

7		< 1	
8	How old is your cat? (circle)	1 to 8	
9		>8	
10	Has (s)he been in any fights in the past 12 months?	YES	NO
11	Does (s)he go outside?	YES	NO
12	What about on a deck, balcony or porch?	YES	NO
13	Do you have other cats? How many? _____	YES	NO
14	Do they go outside?	YES	NO

Canine History Questions

15		< 1	
16	How old is your dog? (circle)	1 to 6	
17		>6	
18	Has your dog missed any heartworm doses in the past 12 months? How many? _____	YES	NO
19	Do you need a refill? Current product? _____	YES	NO
20	Have you ever found fleas/ticks on your dog?	YES	NO
21	Do you need a prevention refill? Current product? _____	YES	NO
22	Does your dog go places where there are deer, foxes, raccoons, etc?	YES	NO
23	Does your dog go places where there are rats?	YES	NO
24	Would you describe your dog as a "city dog"?	YES	NO

Please circle all that apply:

History	Increased drinking	Increased urination	Diarrhea	Vomiting	Behavior changes	Seizures/Epilepsy
	Changes in appetite	Exercise intolerance	Weight changes	Sneezing	Coughing/Wheezing	Lameness
	Difficulty with stairs	Itching	Flaky skin	Unusual odor	Shaking head	Ear discharge
	Scratching	Rash	Hair loss	Scotting	Lumps or growths	Restless/pacing at night
	Dropping food	Difficulty eating	Bad breath	Eye Discharge	Cloudy Eyes	Squinting