



Patient Information Form

PLEASE COMPLETE ALL QUESTIONS

Owner/Guardian/Agent Name: _____

Animal's Name: _____ Species: Cat Dog Gender: Male Female

Animal's Breed: _____ Color: _____ Age: _____

Telephone numbers for today: _____ Alternate Phone # for today: _____

How long have you had this animal? _____

Where did you get him/her? _____

Name & phone number of person authorized to make treatment decisions: _____

Pre-surgical question	Yes	No	Don't know	
Has your animal eaten since midnight last night?				If yes, time: _____
Within the last 2 weeks, has your pet had: coughing, sneezing, vomiting or diarrhea?				If yes, details: _____
Is pet on medication?				If yes, what medication? _____ for how long? _____ How much? _____
Have there been any changes in eating, drinking or behavior?				If yes, explain: _____
Has your pet ever had a seizure?				If yes, explain, and list medication: _____
Has your pet had surgery before?				If yes, explain: _____
Have there been any reactions to vaccinations, drugs or medications?				If yes, explain: _____
Does this animal have any health problems?				If yes, explain: _____
Has he/she had a serious injury (hit by car/ attacked by another animal)?				If yes, describe: _____
In the past ten days, has your animal been treated for fleas, ticks or mange?				If yes, what product and route of application? _____

If animal is female:

Has she been in heat yet?				If yes, when: _____
Is she pregnant?				
If she has had a litter, has it been at least 2 weeks since the babies nursed?				

Signature _____ Date _____

**IF ANIMAL IS A DOG WOULD YOU LIKE TAKE HOME PAIN MEDS?
CIRCLE ONE YES NO**

Form date 713/09