History Form - Canine & Feline - *Initial or Annual Exam*

North Central Animal Hospital

____________ ________________________ ______________ ___________ _________

Date Client name Pet Name Species Acct. #

Initial Exam: Source: Breeder, Pet Store, Shelter, Stray, Other_________________________ Date obtained: __________

Approximate age when obtained: ____________ Number of previous owners: ___________________________

Any prior veterinary exam, or since last visit here? No Yes, Date: ______ Hospital Name:____________________

*Reason for visit:*____

Previous Vaccinations: (when & where) ____

Main reason for visit: ____

____

How long have any problems been noted? ____

Diet Fed: Brand of dry and/or canned: ____

Amount_________________ Frequency_____________ Table food________________ Treats____________

Body Weight: no change weight loss weight gain **Diet changes since last visit:** No Yes

Appetite: normal increased decreased **My pet last ate:**__________ (am / pm)

Drinking: normal increased decreased

Attitude/Activity: normal increased decreased

Medications/Parasite control/Supplements: No Yes:

Other Pets in household: No Yes, List type & number____

____

Exercise & Travel: -*Indoors only, never outside:* Yes No -*Supervised at all times when outside:* No Yes

Out of state: No Yes, Locations visited or future plans:___________________________________

Local/routine: Park Neighborhood Walks Mountain Preserve Pet Store Other________________

Grooming/Bathing: **No** **Yes** *self* *professional groomer* frequency:____________________

Boarding/Daycare: No Yes, Location_____________________ frequency:___ ____________________

Home Dental Care: No Yes, Type__ ____

Dental problems noted: No Yes: bad breath tartar toothloss other:

Pain: No Yes mild moderate severe Location:

Limping: No Yes, Location & when noted:

: **Difficulty rising/stiffness:** No Yes When noted:

Seizures: No Yes, age first started, frequency, duration: _________________________________

Urination: normal abnormal *More Volume* *More Frequent* *Straining* *Leaking* *Blood* *Marking*

Feces (stool): normal abnormal, *too firm/dry* *soft* *diarrhea* *blood* *straining* *frequent* *worms*

Flatulence (gas): No Yes, Is this something you would like reduced? No Yes

Litter Box: No Yes (number of boxes:_____________, type of litter____________)

Vomiting: No Yes, Frequency: _____________________ Describe:_____________________________

Coughing: No Yes, Frequency: ____________________________________

Sneezing: No Yes, Frequency: ____________________________________

Breathing: *Select:* *normal* *increased effort* *panting more* *other*_____________________________

Spayed/neutered: Yes: *Age when altered*________ / No: *Last heat cycle:*_______ *Duration of heat cycle*_______

Allergies or negative vaccine reactions: No Yes,______________________________

Skin problems :

Scratching/Itching/Licking/Wounds: No Yes

Lumps/bumps/swellings: No Yes

Fleas or Ticks noted No Yes

Skin or Hair coat changes: No Yes

Scooting on bottom: No Yes

Eye:

Discharge, squinting, other: No Yes

Vision changes: No Yes

Ear:

Discharge, odor, shaking head: No Yes

Hearing loss: No Yes

Describe any noted as Yes above:____

Behavioral concerns: No Yes, *Select:* *Excessive barking,* *property destruction,* *aggression,* *house soiling,* *marking,* *pacing/circling,* *eating feces,* *other* _________________________________

Microchip or Tattoo? No Yes

Any other specific concerns?

Please email completed form to: NorthCentralReceptionists@gmail.com