



# 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? \_\_\_\_\_

**IS YOUR PET MICROCHIPPED? \_\_\_\_\_ IF NOT, MICROCHIP HIM/HER TODAY? YES NO**

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 1/25/11