

PATIENT HISTORY FORM

Client Name: _____

Patient Name: _____

Date: _____

Preferred Pick Up Time: _____ Permission to treat? Y N

Lab work? Y N

X-rays? Y N

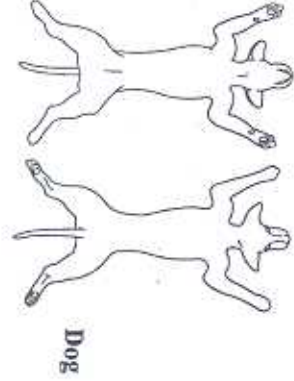
Phone # we may reach you at: () _____

Name of person completing this form: _____

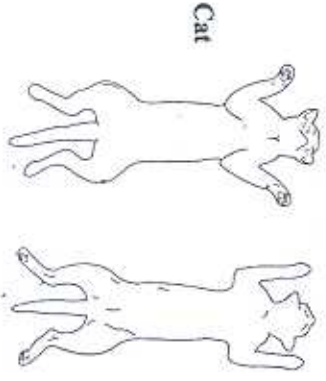
Please review the following and check those symptoms which your pet is experiencing and explain briefly where applicable.

GENERAL -	GASTROINTESTINAL -
Energy Level _____	Vomiting _____
Appetite _____	Diarrhea _____
Drinking _____	Constipation _____
Weight Loss/Gain _____	Blood/Mucous in Stool _____
RESPIRATORY -	Eating Stool or Foreign Material _____
Coughing _____	URINARY/GENITAL SYSTEM -
Sneezing _____	Difficulty Urinating _____
Difficulty Breathing _____	Frequent Urinating _____
Fainting _____	Urines in Inappropriate Places _____
LAMENESS -	Blood in Urine _____
Limping _____ Which leg _____ How long _____	Vaginal Discharge _____
Worse when first up _____ Worse after exercise _____	EYES -
SKIN - Please mark areas affected on pet drawing below	Discharge or Redness _____ Vision Problem _____
Itching _____ Hair loss _____ Lumps/Bumps _____ Dry skin _____	EARS -
	Odor _____ Discharge _____ Shaking Head _____ Swollen Ear Flap _____
	NOSE -
	Discharge _____ Which Nostril _____ Bleeding _____
	NERVOUS SYSTEM -
	Seizures _____ Incoordination _____ Paralysis _____ Shaking _____
	CURRENT MEDICATIONS - List and note when last dose was given

PET DRAWING



Dog



Cat