## Sunnycrest Animal Care Center Patient History Form

Patient Name:	Client Name:	Cell Phone Number:		
Name of Medication Dos  1  2  3	receptionist new information! his elsewhere? □Yes □No  plement doses and frequency e/Last given Frequency  s □No	Skin    Itching   Masses/Lumps   Wounds   Swelling or Reduce   Hair loss   Dandruff   Odd   Muscles and Bones   Limping   Swelling   If Limping which Leg?   R.Front   L.Front   R.Hind   For how long?   Respiratory   Sneezing   Nasal Discharge   Cough   Labored Breathing   Fainting   Gastrointestinal   Vomiting   Diarrhea   Constipation   Rectal Bleed   Scooting   Bad Breath	□L.Hind  e g	Genital/Urinary System  □ Breast lumps □ Discharge-Penis □ Discharge-Vulva/vagina □ Straining to urinate □ Bloody urine □ Unable to urinate  Neurological □ Shaking □ Seizures □ Paralysis □ Staggering □ Eyes Twitching  Eyes & Ears □ Red Eyes □ Eye Discharge □ L □ R □ L □ R □ Blind: □ left □ right □ both  Other: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
Current Diet:Amount Fed:Frequency:		Please Mark on The Drawings any masses or lesions (sores) and note below Sizes/when first appeared and if growing:  Thank you for helping us make your pet's exam go smoothly.		
Any food allergies?  Yes No When was last meal: Appetite: Good Fair Poo Water Consumption: Norma Any history of ingesting a foreig Current Monthly Flea Control P Current Monthly Heartworm Pr Any Recent Travel: Yes No Any Exposure to Toxins or Poiso	r		Notes:	