

PATIENT REGISTRATION AND HISTORY

Owner _____ Patient /Pet _____

Dog or Cat? Breed _____ Color _____ Sex ____ Neutered? Y or N When _____

Birth Date or Age _____ How old when obtained? _____

Where obtained from? _____

Number and types of other pets in household? _____

Do any of these pets have similar problems? _____

General Environment (i.e. rural, suburban, city) _____

Runs free, leashed walked, fenced in yard, etc. _____

List type of: Diet? _____ Table Food? _____

Treats _____ Toys? _____

Things (other than food) your pet eats? _____

Diseases diagnosed in the past: (Please circle all that apply)

Heart	Cushing's or Addison's	Thyroid-Hypo/Hyper
Diabetes	Intestinal/Stomach	Skin/Ear
Seizures	Kidney Liver	Pancreas
Respiratory/Nasal	Eye	Other:

Current Medications:

Thyroid	Anti-Seizure	Insulin	Vitamins
Lysodren	Steroid	Pain	Minerals
Allergy	Behavioral	Heart	Supplements
Antibiotics	Motility enhancer	Antacids	Holistic
Blood Pressure	Other:		

Heartworm Preventative (Brand) _____

Flea Preventative (Brand) _____

When was your dog or cat last vaccinated: Rabies Date _____; Distemper Date _____

Parvo Date _____ Lyme Date _____ Felv/FIP Date _____

Has your pet ever been hit by a car or sustained trauma of any sort? _____

Prior surgeries: _____

List names of all other Veterinarians that have seen your pet in the past: _____

How did you hear about our hospital? (Please circle)

Yellow Pages Newspaper Primary Veterinarian Other: _____