OPTIONS
VETERINARY CARE

Comprehensive Patient Medical History Form

Patient ID# (For Office Use): _____ **Date of Visit:** _____

Owner Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Mobile Phone: _____ **Home Phone:** _____

Email: _____

Pet Name: _____ **Species:** _____

Sex: _____ **Spayed or Neutered?** ☐ Yes ☐ No **Age:** _____ **Color(s):** _____

Breed: _____

- What is the reason for your pet's visit today?

  _____

  _____

  _____

  How long has it been going on for? _____

  Has your pet been examined elsewhere for the same condition? ☐ Yes ☐ No

  If yes, where? _____
- Does your pet have any medical/health conditions? ☐ Yes ☐ No
  If yes, please list: _____
- Is your pet on any medications (flea/tick medications, vitamins, supplements, and/or injections)? ☐ Yes ☐ No
  If yes, please list: _____
- Is your pet allergic to any food, medication, or treatment? ☐ Yes ☐ No

  If yes, please list: _____
- Are your pet's vaccinations up-to-date? ☐ Yes ☐ No

  If not, would you like your pet to be vaccinated today? ☐ Yes ☐ No
  - If yes, what vaccine(s) would you like your pet to receive today? _____
- Has your pet ever had a seizure? ☐ Yes ☐ No

  If yes, when did it start? _____

  If yes, when was the last episode? _____

  If yes, how often does your pet have a seizure? _____
- What is the name of your pet's current diet? _____

  How much do you feed your pet each day and how often? _____
- Does your pet get table scraps? ☐ Yes ☐ No If yes, please list: _____
- Has your pet had any recent vomiting? ☐ Yes ☐ No

If yes, when did the vomiting start? _____

If yes, when was the last episode? _____

If yes, how often does your pet vomit? _____

- Has your pet had any recent ☐ Coughing ☐ Sneezing ☐ Gagging?

  If yes, when did it start? _____

  If yes, how often does it occur? _____

- Has there been any change in the nature of your pet's urine or urination habits? ☐ Yes ☐ No

  If yes, please explain: _____

- Does your pet have any recent ☐ Diarrhea ☐ Constipation?

  If yes, when did it start? _____

- Is your pet exhibiting any ☐ Stiffness ☐ Weakness ☐ Lameness?

  If yes, when did it start? _____

  If yes, what limb(s) is/are affected? ☐ Right Front ☐ Left Front ☐ Right Back ☐ Left Back

- Does your pet have any pain? ☐ Yes ☐ No If yes, where? _____
- Is your pet scratching? ☐ Yes ☐ No If yes, where? _____
- Does your pet have any hair loss? ☐ Yes ☐ No If yes, where? _____
- Your pet is mainly: ☐ Indoor ☐ Outdoor
- Do you travel with your pet? ☐ Yes ☐ No

  If yes, please list where: _____

- Please check one of the following (same, increased, or decreased) for each row:

	Same?	**Increased?**	**Decreased?**	**If increased or decreased, when did it start?**
Drinking				
Appetite				
Urination				
Weight				

- Anything else you would like for us to know?

_____

_____

_____

_____