DOG HISTORY

Pet: ____________________ Owner: ____________________________ Date: ______________

Today's Weight: ____________ Today's Temp: ____________ Today's Age: ____________

Owner info (address, phone numbers, etc) still current? [] Yes [] No Photo taken ______________

Chief Complaint or Reason for Visit: [] Routine Vaccinations
[] Other ____

Has your pet been seen for **same condition** recently? [] Yes [] No (When: _______________________)
Vaccinations up to date? [] Yes [] No
Spayed / Neutered? [] Yes [] No
Heartworm preventive used? [] Yes [] No (What kind? ____________________)
Flea control used? [ ] None [] Frontine® [] Advantix® [] Other: ______________Working? [] Yes [] No
Does your area have tick s your dog could be exposed to? [] Yes [] No
Are mosquitoes or biting flies a problem in your area? [] Yes [] No
How often do you bathe your pet? ______________ What shampoo used? ___________________
Does your pet swim? [] Yes [] No If yes, how often?___________________________________
Any **worms** seen? [] Yes [] No (Describe: _____________________)
Any **injury or illness** in past 30 days? [] Yes [] No (Describe: _____________________)
On any **medications/supplements**? [] Yes [] No (Describe: _____________________)
Has your pet ever had any **adverse reaction** after vaccinations or drugs/medications: [] Yes [] No
Time **outdoors**? []Daily for bathroom/walks []50:50 Indoor/outdoor []Outdoor only
Is your dog exposed to other dogs? [] Yes [] No (board, groom, obedience class, walks through the fence)
Is your dog exposed to wildlife? [] Yes [] No (large yard, hunt, hike off-leash, drink from puddles)
Other pets in the house? ____
Are your other pets vaccinated and on heartworm and flea and tick preventative, if applicable? [] Yes [] No
Diet: _____________________________________ How many times / day do you feed your pet? ________

Table scraps?	[ ] Yes [ ] No			
Appetite:	[] Increased	[] Normal	[] Decreased	
Water Consumption?	[] Increased	[] Normal	[] Decreased	
Weight:	[] Gain	[] Stable	[] Loss	
Bowel Movements?	[] Normal	[] Constipated	[] Diarrhea	[] Bloody
Urination?	[] Normal	[] Increased	[] Decreased	[] Bloody
Vomiting?	[] Yes	[] No		
Coughing or sneezing	[] Yes	[] No		
Any Listlessness?	[] Yes	[] No		
Any Seizures?	[] Yes	[] No		
Shaking Head?	[] Yes	[] No		
Scratching/Scooting?	[] Yes	[] No		
Significant Hair Loss?	[] Yes	[] No	[] Patchy [] Generalized [] Excessive Shedding	
Unusual Lumps or Bumps?	[] Yes	[] No	(Location: ___________________________________)	
Bad Breath?	[] Yes	[] No		
Unusual Discharge?	[] Yes	[] No	(Location: ___________________________________)	
Lameness?	[] Yes	[] No	(Which Leg? [] RF [] LF [] RR [] LR)	
Stiffness or Difficulty Rising?	[] Yes	[] No	After sleeping? [] Yes [] No After exercise? [] Yes [] No	
Any Behavioral Changes?	[] Yes	[] No	(Describe: ______________________________________)	

Do you need any flea and tick or heartworm preventative today? [] Yes [] No