Animal Clinic of Edgewater

Patient History Questionnaire

Our animal companions age much more quickly than we do. For this reason, routine physical examinations are an extremely important part of maintaining your pet's health and quality of life. You are your pet's most important advocate.

Please assist our medical staff to provide a thorough assessment of your pet's health by completing this questionnaire.

Owner's Name: _____

Address: _____

Phone # (where you can be reached):_____

Patient Name: _____

Canine: _____ **Feline:** _____ **Other:** _____

Age:_____ **Sex:**_____ **Spayed/Neutered:**_____

Presenting Complaint / Reason for today's visit: _____
_____
_____
_____
_____

Diet and Environment

1. What food does patient currently eat? _____

Amount & Frequency? _____

2. Does patient consume treats? **Yes / No**

If yes, what kinds? _____

3. Is patient on any dietary supplements? **Yes / No**

If yes, what kind and what dosage? _____

4. Does patient consume table food? **Yes / No**

If yes, please explain: _____

5. Is patient primarily indoor or outdoor? _____

6. Are there any other animals in the household? **Yes / No**

If yes, are any of them sick? _____

7. Do you board your pet? **Yes / No**

If yes, how often? _____

8. Do you have your pet groomed or bathed outside of your home? **Yes / No**

If yes, how often? _____

Review of Signs

1. Has patient exhibited any attitude or behavior change? **Yes / No**

If yes, please explain: _____

2. Has patient ever had seizures? **Yes / No**

If yes, please explain: _____

3. Any recent appetite changes? **Yes / No**

If yes, please explain: _____

4. Does patient have any exercise intolerance? **Yes / No**

If yes, please explain: _____

5. Does patient have any increased thirst and/or urination? **Yes / No**

If yes, please explain: _____

6. Has patient had a decrease in urination? **Yes / No**

If yes, please explain: _____

7. Any recent weight changes? **Yes / No**

If yes, please explain: _____

8. Has patient been vomiting? **Yes / No**

If yes, please explain: _____

9. Has patient had any diarrhea? **Yes / No** If yes, any blood in stool? **Yes / No**

If yes, please explain: _____

10. Has patient been coughing? **Yes / No**

If yes, please explain: _____

11. Has patient been sneezing? **Yes / No**

If yes, please explain: _____

12. Has patient exhibited any signs of lameness? **Yes / No**

If yes, please explain: _____

13. Does patient have difficulty rising after lying down? **Yes / No**

If yes, please explain: _____

14. Has patient been itching? **Yes / No**

If yes, please explain: _____

15. Has patient had any recent hair loss? **Yes / No**

If yes, please explain: _____

16. Does patient have any growths on body? **Yes / No**

If yes, please explain: _____

17. Does patient have any discharge from nose, eyes, vulva, etc.? **Yes / No**

If yes, please explain: _____

18. Has patient had any change in sleep patterns? **Yes / No**

If yes, please explain: _____

Reason for Visit (For sick patients)

1. When did the problem start or how long has the problem been occurring?

_____
_____
_____
_____
_____

2. What were the first signs of the problem and how did it progress?

_____
_____
_____
_____
_____

3. Was patient seen by another doctor for this problem? **Yes / No**

If yes, when: _____

4. Were any treatments given by you or another doctor? **Yes / No**

If yes, what and at what dosage?

_____
_____

Past History (For new patients)

1. How long have you had the patient? _____

If you acquired patient recently, from where? _____

2. Has patient traveled recently to or from Florida (within 6 months)? **Yes / No**

If yes, where and when? _____

3. Has your pet been microchipped? **Yes / No**

If yes, has the microchip been registered? _____

4. Is patient on flea prevention? **Yes / No**

If yes, what type and how often? _____

5. Is patient on heartworm prevention? **Yes / No**

If yes, what type and how often? _____

6. Has patient been tested for heartworms? **Yes / No**

If yes, when? _____

7. Has the patient been exposed to ticks? **Yes / No**

If yes, please explain: _____

8. Is patient used for hunting? **Yes / No**

Is patient taken camping or on outdoor trips? **Yes / No**

9. Is patient used for breeding? **Yes / No**

If yes, is she pregnant or is he currently standing? **Yes / No**

10. Has patient had any prior illnesses, accidents, or surgeries? **Yes / No**

If yes, please explain: _____

11. Is patient aggressive or fearful around strangers? **Yes / No**

If yes, please explain: _____

12. Aside from heartworm, flea & tick preventatives, is patient given any other medication?

Yes / No If yes, please explain: _____

13. Does patient have any known allergies to any medications? **Yes / No**

If yes, please list: _____

14. Has patient ever had a reaction to any vaccines? **Yes / No**

If yes, please list and explain below:

_____

_____

_____

Signature Date