



Recent Medical History

Pet's Name: _____ Date: _____

Has your pet shown any of the following signs or symptoms?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Lumps or Bumps
<input type="checkbox"/>	<input type="checkbox"/>	Lameness or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Itching or Scratching
<input type="checkbox"/>	<input type="checkbox"/>	Listlessness or Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Poor Coat/Hair Loss
<input type="checkbox"/>	<input type="checkbox"/>	Tremors or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Head Shaking
<input type="checkbox"/>	<input type="checkbox"/>	Coughing or Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Unusual Body Odors
<input type="checkbox"/>	<input type="checkbox"/>	Scoting on the Rear End	<input type="checkbox"/>	<input type="checkbox"/>	Unusual Discharges

If yes, please explain: _____

Has your pet shown significant change in any of the following?

Yes	No	Please Circle the Appropriate Answer	
<input type="checkbox"/>	<input type="checkbox"/>	Appetite?	Increased Decreased
<input type="checkbox"/>	<input type="checkbox"/>	Water Intake?	Increased Decreased
<input type="checkbox"/>	<input type="checkbox"/>	Character of Bowel Movement?	
		Diarrhea	Constipation
		Increased Frequency	Decreased Frequency
<input type="checkbox"/>	<input type="checkbox"/>	Frequency or Amount of Urination?	
		Increased Frequency	Increased Volume
		Decreased Frequency	Decreased Volume
<input type="checkbox"/>	<input type="checkbox"/>	Change in Body Weight?	Gain Loss
<input type="checkbox"/>	<input type="checkbox"/>	Behavior?	Explain: _____

Brand of Normal Diet: _____

Number of meals per day: _____ Amount per meal (cups of food): _____

Treats (brand/type): _____ Number of treats per day: _____

Medications/Supplements: _____

Is there anything else we need to know? _____

Lifestyle Questionnaire

In an effort to base our vaccination recommendations upon your dog's disease risks, we are asking that you take a few moments to answer the following questions regarding your dog's daily life.

Yes No

1. Do you board your dog or take your dog to a groomer?
2. Do you take your dog to pet stores, dog training classes, or other places where your dog is exposed to other dogs?
3. Do you bring your dog along while walking, jogging, picnicking, hiking, camping, hunting, or fishing?
4. Do you bring your dog along while visiting Northeast Iowa, Minnesota, Wisconsin, or the Northeastern United States?
5. Do you ever find ticks on your dog?
6. Has your pet ever had a reaction to a vaccination in the past (soreness, lethargy, swollen face, vomiting, and/or diarrhea)?

Who is your pet insurance carrier? _____

Heartworm preventative brand: _____

Flea control product: _____

Strict monthly use (___) or, I skip the occasional dose (___)

I understand that Heartland Animal Hospital recommends screening my pet for external (fleas and ticks) and internal (intestinal parasites and heartworms) parasites, which can cause disease not only in my pet, but also in my human family members as well. I also understand that Heartland Animal Hospital recommends year-round once monthly doses of preventives for both external and internal parasites. Further, I understand that if I choose not to follow these recommendations, I am leaving my pet and family members vulnerable and can not hold Heartland Animal Hospital responsible for disease caused by these parasites.

X _____ Date: _____