Recent Medical History

Pet's Name: _____ Date: _____

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

Yes	No		Yes	No	
☐	☐	Vomiting	☐	☐	Skin Problems
☐	☐	Diarrhea	☐	☐	Lumps or Bumps
☐	☐	Lameness or Stiffness	☐	☐	Itching or Scratching
☐	☐	Listlessness or Weakness	☐	☐	Poor Coat/Hair Loss
☐	☐	Tremors or Seizures	☐	☐	Head Shaking
☐	☐	Coughing or Sneezing	☐	☐	Unusual Body Odors

If yes, please explain: _____

_____

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

Yes	No	Please Circle the Appropriate Answer
☐	☐	Appetite? Increased Decreased
☐	☐	Water Intake? Increased Decreased
☐	☐	Character of Bowel Movement? Diarrhea Constipation Increased Frequency Decreased Frequency
☐	☐	Frequency or Amount of Urination? Increased Frequency Increased Volume Decreased Frequency Decreased Volume
☐	☐	Change in Body Weight? Gain Loss
☐	☐	Behavior? Explain: _____

_____

Brand/Type of Normal Diet: _____

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

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

Bedding/Housing (please describe): _____

Is there anything else we need to know? _____

_____

_____

_____