

All Pets Emergency & Referral Center, P.C.

NEW PATIENT HISTORY SHEET

Patient Name: _____ Date: _____

Date of Birth: _____ Sex: M F Neutered/Spayed: Y N

Species: Feline Canine Breed: _____

If feline: Indoor Outdoor Indoor & Outdoor

What is your pet's current problem: _____

Do you have any other pets at home? (If yes, what are they?) _____

What do you currently feed your pet? _____

When your pet was last vaccinated? _____

Are you using any flea/tick/heartworm preventive? (please list) _____

Has your cat been tested for feline leukemia and/or FIV? (if yes, when and results:) _____

Has your dog been tested for heartworm and/or lyme disease? (if yes, when and results:) _____

Please list any previous health problems, surgeries or allergies we should know about:

Please list current medications (including over-the-counter, supplements, herbal remedies), when started, dosage and response:

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Has your pet exhibited any of the following? (Please circle all that apply)

Lethargy	Yes	No			
Drinking an abnormal volume	Yes	No			
Frequent or difficult urination	Yes	No			
Urinating an abnormal volume	Yes	No			
Changes in appetite	Yes	No			
Vomiting	Yes	No			
Diarrhea	Yes	No			
	If yes, please circle all that apply	Blood	Clear Mucous	Straining	Black stool
Constipation / difficulty defecating	Yes			No	
Recent weight loss	Yes			No	
Coughing	Yes			No	
Sneezing	Yes			No	
Abnormal Breathing	Yes			No	
Gagging / retching	Yes			No	

For each "Yes" circled above, please describe frequency, duration, progression, response to treatment, and/or any other information:

Does your pet have any other problems we should know about?
