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:

_____

_____

_____

_____

_____

_____

6460 Highway 9, North ● Alpharetta, Georgia 30004
(678) 366-2500

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?

_____

_____

_____

_____

_____

_____