PVSEC- Internal Medicine/Oncology

PATIENT HISTORY FORM

Patient Name:_____ Date:_____

If feline: Indoor Outdoor Indoor & Outdoor

What is your pet's current problem:_____

_____

_____

_____

Do you have any other pets in the same household? If yes, what are they?_____

_____

What do you currently feed your pet?_____

When was your pet last vaccinated?_____

Has your pet traveled in the past year? If so, where?_____

Are you currently using any flea/tick/heartworm preventive? If so, what brand?_____

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

_____

Is your pet on medications/supplements? If so, please list **current** medications.

Medication:_____Dosage/frequency:_____Response:_____

Medication:_____Dosage/frequency:_____Response:_____

Medication:_____Dosage/frequency:_____Response:_____

Medication:_____Dosage/frequency:_____Response:_____

Has your pet recently been on medications that are now **discontinued or completed**? If so, please list.

Medication:_____Dosage/frequency:_____Response:_____

Medication:_____Dosage/frequency:_____Response:_____

Medication:_____Dosage/frequency:_____Response:_____

OVER→

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

1. Lethargy Yes No
2. Drinking an abnormal volume Yes No
3. Frequent or difficult urination Yes No
4. Urinating an abnormal volume Yes No
5. Changes in appetite Yes No
6. Vomiting Yes No
7. Diarrhea Yes No
   If yes, please circle all that apply Blood Clear Mucus Straining Black stool
8. Constipation/difficulty defecating Yes No
9. Recent weight loss Yes No
10. Coughing Yes No
11. Sneezing Yes No
12. Abnormal breathing Yes No
13. Gagging/retching Yes No

STAFF USE ONLY: T:_____ HR:_____ R:_____ mm/CRT:_____ Weight:_____kg

Symptom Number	Characterize	Date of onset	Frequency	Progression	Response to therapy