Patient Medical History Form

Animal Health Care Center

Client Name: _____

Patient Name : _____

Phone Number: _____

1. Reason for the visit:

2. Current Diet:

3. History of seizures? ☐ Yes ☐ No

4. History of cancer? ☐ Yes ☐ No

5. Any medications? (i.e. current prescriptions,over-the-counter medications, supplements, flea/tick/heartworm prevention)

6. Do you need any prescriptions refilled?

7. If your pet is a cat, are they ☐ Indoor ☐ Outdoor ☐ Both

Symptom	Yes or No	If Yes, please check all that apply
Change in appetite?	☐ Yes ☐ No	☐ Not eating ☐ Only eats treats ☐ Decreased appetite ☐ Increased appetite
Change in water intake?	☐ Yes ☐ No	☐ Increased ☐ Decreased ☐ Not drinking at all
Vomiting?	☐ Yes ☐ No	☐ Vomiting white foam ☐ Blood in vomit ☐ Vomiting yellow/green fluid ☐ Vomiting Food ☐ Got into trash ☐ Fed table scraps ☐ Has history of eating toys/string/clothing
Diarrhea?	☐ Yes ☐ No	☐ Watery/runny stool ☐ Soft but formed stool ☐ Blood in stool ☐ Mucous or slime in stool ☐ Soft stool without form to it
Coughing?	☐ Yes ☐ No	☐ Moist cough ☐ Dry cough ☐ Occurs at night ☐ Occurs during the day ☐ After/during activity ☐ After/During drinking water
Sneezing?	☐ Yes ☐ No	☐ Increased Frequency ☐ Mucoid nasal discharge ☐ Clear Nasal Discharge ☐ Watery eyes

Please initial the following:

_____ I understand the doctor will contact me after examining my pet to discuss findings and a treatment plan. No treatment or testing will proceed without my authorization. Payment is due at discharge.

Please choose one of the following:

☐ **YES, I authorize** Animal Health Care Center to perform emergency care for my pet until I'm reached. I accept responsibility for any related charges.

☐ **NO, I do not** authorize Animal Health Care Center to perform any emergency procedures without contacting me first.

Signature: _____ **Date:** _____