Erlanger Veterinary Hospital

CANINE/FELINE
Your Pet's Medical Information & History

Your Name: _____ Pet's Name:_____ Date:_____

INSTRUCTIONS: Please circle YES or NO

Reason for today's visit? _____

Has your address or phone number changed since your last visit? **YES/NO**
If yes, please specify any changes: _____

What is your e-mail address?_____

Have you been to our satellite office, Union Pet Hospital, recently? _____

Are you interested in Pet Insurance?	**NO**	**YES**
Does your pet travel out of state? (If yes, where?)	**NO**	**YES:_____**
Do you board or groom your pet?	**NO**	**YES**
Do you brush your pet's teeth?	**NO**	**YES**

What is your pet's diet (Brand)?_____

*Has your pet shown any of the following **signs** or **symptoms**? If yes, please **circle the symptom***

UNUSUAL BODY ODORS BAD BREATH SHAKING HEAD/EARS

COUGHING SNEEZING WHEEZING GAGGING CHOKING

ITCHING HAIR LOSS SKIN PROBLEMS POOR HAIR COAT

VOMITING DIARRHEA SCOOTING REAR END LUMPS BUMPS

LIMPING LAMENESS STIFFNESS LISTLESS WEAKNESS SEIZURES

UNUSUAL DISCHARGE SQUINTING EXCESSIVE PANTING TREMORS

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

Character of bowel movements?	**YES**	**NO**	Appetite?	**YES**	**NO**
Frequency or amount of urination?	**YES**	**NO**	Drinking?	**YES**	**NO**
Weight gain or loss?	**YES**	**NO**	Behavior?	**YES**	**NO**