



General New Patient Information Form

In order for us to serve you and your pet better, please take a moment to complete this Patient Information Form.

Today's Date: _____ Appointment Time: _____

PATIENT'S NAME: _____ <div style="text-align: center; margin-top: 5px;">(Last Name)</div>	_____ <div style="text-align: center; margin-top: 5px;">(First Name)</div>
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How did you acquire your pet? Breeder Store Shelter (Please provide name and location below)

_____ Date: _____

CURRENT DIET

Free choice Set meals per day

Brand name: _____ Amount/day: _____ Canned: ___ Dry: ___ # Meals/day: _____

Brand name: _____ Amount/day: _____ Canned: ___ Dry: ___ # Meals/day: _____

Any known food allergies/intolerance? Yes. No. If YES please indicate known allergies or allergen testing done:

VACCINE HISTORY

Last vaccine given: _____ Date: _____

TRAVEL HISTORY

Please indicate location, approximate date and length of visit:

DRUG REACTIONS

Please indicate any known adverse reactions/allergies to vaccines, oral medications, anesthetics and/or topical drugs or shampoos:

CURRENT MEDICATION

Please list all medications including topical medications, flea prevention and herbal/vitamin supplements:

Medication	Dosage	Frequency

Do you have any other pets at home? Yes. No.

If YES Has your other pet(s) been diagnosed with any types of illness recently? Yes. No.

MEDICAL HISTORY

Have you noticed any of the following in your pet (please check appropriate boxes):

1. Change in water intake. If **YES**, have you noticed an increase or decrease

Total water intake: _____ cups/day Measured Approximate

2. Change in urination. If **YES**, have you noticed any straining blood

Frequency: _____ times per day

3. Vomiting. If **YES**, please describe (i.e. bile/undigested food/blood) and include frequency:

4. Diarrhea. If **YES**, have you noticed any blood mucous

Frequency and consistency: _____

5. Change in appetite.

6. Change in body weight.

Has your pet exhibited any other symptoms? Yes. No. If YES, please describe behaviour changes:

Has your pet recently had an X-ray? Yes. No. If YES, how long ago? _____

Please list any previous medical problems:

Date	Condition

DATE: _____ SIGNATURE: _____