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CANADA WEST
VETERINARY SPECIALISTS

PET OWNER FORM

1988 Kootenay Street
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Internal Medicine Re-check Form

Please take a moment to answer the following questions as best as you can to help us treat your pet.

OWNER NAME: First: _____ **Last:** _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

PET'S NAME: _____

PET'S D.O.B.: _____ **PATIENT NUMBER:** _____ **(internal only)**

Has your pet been fasted (no food since midnight) for this appointment? ☐ Yes ☐ No

Please list all current medications and doses:

Medication: _____ Dose: _____ Times/day: ___ Refills required? ☐ Yes ☐ No

Medication: _____ Dose: _____ Times/day: ___ Refills required? ☐ Yes ☐ No

Medication: _____ Dose: _____ Times/day: ___ Refills required? ☐ Yes ☐ No

Medication: _____ Dose: _____ Times/day: ___ Refills required? ☐ Yes ☐ No

What is the current diet?

Food type/brand: _____ Feedings/day: _____

Since your pet's last visit, please comment on habits below (check all that apply):

Eating: ☐ No change ☐ Less ☐ More **Drinking:** ☐ No change ☐ Less ☐ More

Urinating: ☐ No change ☐ Less ☐ More **Vomiting:** ☐ No change ☐ Less ☐ More

Diarrhea: ☐ No change ☐ Less ☐ More

Overall attitude: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you visited a veterinarian since we last saw you? ☐ Yes ☐ No

If yes, please note the reason:

CONTINUED ▶▶

Were any of the following taken/done? (check all that apply)

☐ Bloodwork ☐ Urine ☐ Radiograph ☐ Medications

Were any medications dispensed or discontinued?

Medication: _____ Dose: _____ Started: _____ Finished: _____

Medication: _____ Dose: _____ Started: _____ Finished: _____

Medication: _____ Dose: _____ Started: _____ Finished: _____

Medication: _____ Dose: _____ Started: _____ Finished: _____

Please note any further comments, questions or concerns you may have:

DATE: _____ **SIGNATURE:** _____