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CANADA WEST
VETERINARY SPECIALISTS

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PET OWNER FORM

Surgery Consultation Questionnaire

PLEASE PRINT CLEARLY. This information is for hospital communication purposes only.

OWNER NAME: First: _____ **Last:** _____

PET'S NAME: _____

PATIENT INFORMATION

☐ **Dog** ☐ **Cat** ☐ **Other** **Breed:** _____

Age (DOB): _____ **Sex:** ☐ M ☐ F ☐ Spayed ☐ Neutered ☐ Intact **Colour:** _____

Do you have insurance for this pet? ☐ Yes ☐ No **If so, please indicate:** ☐ PetSecure ☐ Trupanion ☐ Pets+Us ☐ 24 Pet Watch ☐ Petplan/Fetch

Origin: ☐ Breeder ☐ Store ☐ Shelter ☐ Other

Does your pet have a bite history? Yes ◯ No ◯

OWNER / PRIMARY CONTACT

Address: _____ **Unit #:** _____

City: _____ **Province/State:** _____ **Postal Code:** _____

Home#: _____ **Cell#:** _____ **Work#:** _____

Email: _____ (so we can email you reports or information)

ADDITIONAL OWNER / CONTACT

First: _____ **Last:** _____

Does this person also have the decision-making authority? ☐ Yes ☐ No

Home#: _____ **Cell#:** _____ **Work#:** _____

Email: _____ **Relation to above:** _____

FAMILY VET INFORMATION

Your regular veterinary hospital: _____

Your veterinarian's name: _____

Have you been to our hospital before? ☐ Yes ☐ No ☐ Unknown. **If so, with which pet?** _____

Professional fees are due at the time services are rendered. Surgery and hospitalization will require a deposit at the time of admittance. We accept cash, debit, Mastercard, VISA and AMEX. We do not accept personal or business cheques.

CONTINUED ▶▶

PATIENT INTAKE FORM

What condition are you bringing your pet in for?

How long has this condition been present? (Please list the date if known)

_____

Has the condition been: worsening ☐ improving ☐ staying the same ☐

If your pet is limping, which limb(s) are affected: Left front ☐ Right front ☐ Left rear ☐ Right rear ☐

Has your pet received any non-medication treatments for this condition? ☐ Yes ☐ No
If YES, please describe:

Please list all current medications that your pet is taking (including flea/tick preventatives and herbal/vitamin supplements), as well as any previous medications used to treat the presenting condition.

Has your pet had any adverse reactions to any medications? ☐ Yes ☐ No
If YES, please describe:

Has your pet recently experienced any of the following?

- Vomiting ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Change in appetite ☐ Yes ☐ No
- Change in body weight ☐ Yes ☐ No
- Change in drinking ☐ Yes ☐ No
- Change in urination (frequency, straining, etc.) ☐ Yes ☐ No

If you answered yes to any of the above, please describe:

Has your pet exhibited any other abnormal symptoms? ☐ Yes ☐ No
If YES, please describe:

Please list any previous medical conditions that your pet has been diagnosed with.

Has your pet had any recent bloodwork? ☐ Yes ☐ No

Has your pet had any recent x-rays taken? ☐ Yes ☐ No

What diet are you currently feeding your pet? Please include type and frequency.

Does your pet have any food allergies? ☐ Yes ☐ No
If yes, please list what your pet is allergic to.

*****_Please note we use peanut butter in hospital_

Is your pet up to date on vaccines? ☐ Yes ☐ No

Is your pet: indoor only ☐ outdoor only ☐ or indoor/outdoor ☐

Has your pet travelled outside of the province? ☐ Yes ☐ No
If yes, please list the location, approximate date and length of visit.