

TIME: _____

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Patient/Owner Information Form

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

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

PET'S NAME: _____

OWNER / PRIMARY CONTACT

Address: _____ **Unit #:** _____

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

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

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

Licence Plate Number: _____ (Needed in case car is blocked / blocking others, or parked in unsafe space)

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 YES, please indicate:** Trupanion PetsPlusUs

Origin: Breeder Store Shelter Other Petsecure/Petline 24Petwatch Fetch/Petplan

Other _____ Policy # _____

Has your pet ever bitten a person or pet? If yes, please describe: _____

ADDITIONAL OWNER / CONTACT

First: _____ **Last:** _____

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

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

Email: _____ **Relation between you and the first contact above:** _____

FAMILY VET INFORMATION

Your regular veterinary hospital: _____

Your veterinarian's name: _____

Have you been to our hospital before? Yes No Unknown **If YES, 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.

If your pet is here for **OUTPATIENT RADIOLOGY**, stop here.  For all other services, please complete pages 2 and 3. ►►

PATIENT: _____

CURRENT DIET

Free choice Set meals per day

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

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

Any known food allergies/intolerance? Yes No

If YES, please indicate known allergies or allergen testing done:

**Please note we use Peanut Butter in hospital*

VACCINE HISTORY

Is your pet vaccinated for the following: *(Vaccines expire in 1-3 years)*

Feline:	Rabies	FVRCP	FELV	None	Unknown / Up to Date
Canine:	Rabies	Bordetella	Leptospirosis	Distemper/Adenovirus/Parvovirus (DA2PP)	

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