

# Healthy Pet History

Pet's Name:			Date:		
<b>COMMON QUESTIONS</b>					
Has your pet received non-vaccine treatments somewhere else in the past 12 months?					
If so, where?	When?	Diagnosis?	Was the problem resolved?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is your pet intact (not spayed/neutered)?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Last Heat? (females only)			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<b>FELINE HISTORY QUESTIONS</b>					
How old is your cat?	<input type="checkbox"/> <1	<input type="checkbox"/> 1-8	<input type="checkbox"/> >8		
Has (s)he been in any fights in the past 12 months?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Does (s)he go outside?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
What about on a deck, balcony or porch?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have other cats? If so, how many? _____			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do they go outside?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<b>CANINE HISTORY QUESTIONS</b>					
How old is your dog?	<input type="checkbox"/> <1	<input type="checkbox"/> 1-6	<input type="checkbox"/> >6		
Has your dog missed any heartworm doses in the past 12 months? How many?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you need a refill? Current product? _____			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you ever found fleas/ticks on your dog?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you need a prevention refill? Current product? _____			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Does your dog go places where there are deer, foxes, raccoons, etc?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Does your dog go places where there are rats?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Would you describe your dog as a "city dog"			<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<b>HISTORY: Check all that apply</b>					
<input type="checkbox"/> Increased drinking	<input type="checkbox"/> Increased urination	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Behavior changes	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Changes in appetite	<input type="checkbox"/> Exercise intolerance	<input type="checkbox"/> Weight changes	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Coughing/Wheezing	<input type="checkbox"/> Lameness
<input type="checkbox"/> Difficulty with stairs	<input type="checkbox"/> Itching	<input type="checkbox"/> Flaky skin	<input type="checkbox"/> Unusual odor	<input type="checkbox"/> Shaking head	<input type="checkbox"/> Ear discharge
<input type="checkbox"/> Scratching	<input type="checkbox"/> Rash	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Scooting	<input type="checkbox"/> Lumps or growths	<input type="checkbox"/> Restlessness/pacing at night
<input type="checkbox"/> Dropping food	<input type="checkbox"/> Difficulty eating	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Cloudy eyes	<input type="checkbox"/> Squinting