Welcome Back! It's Good To See You Again!

OWNER

Please fill out the following information
Name_____
Address_____
City_____ ST____
Zip_____
Home phone_____
Cell/Other_____

Would You Like To Recieve Informational Newsletters From The Animal Medical Center? If So, Please Give Us Your Email Address.

Email Address_____

PATIENT

Pet Name_____

Sex_____ Color_____

Breed_____

How do you view your pet?
- ❑ Like a family member, I am concerned about all health issues
- ❑ Simply as a pet, I am not as concerned about all health issues

Would you like us to keep you updated on ways to lengthen your pet's life?
- ❑ Yes
- ❑ No

Health Questionaire

Have you medicated your pet recently? ❑ Yes ❑ No If so, what meds did you give?_____

What brand of food do you feed your pet?_____ How much and how often?_____

Does your pet get table food? If so, what kind?_____

How much water does your pet drink in a 24 hour period?_____ cups quarts gallons

Do you give vitamins or supplements? ❑ Yes ❑ No

On average, how long does your pet spend outside?_____hours

What type of exercise does your pet get?_____ How long?_____ How often?_____

How many pets live in your house?
_____Dogs
_____Cats
_____Other?

Are all your pets on flea preventative medications? ❑ Yes ❑ No

If yes, what do you use?_____

- ❑ Yes ❑ No Do you take your pet to a groomer?
- ❑ Yes ❑ No Have you noticed a loss of hearing in your pet?
- ❑ Yes ❑ No Do you board your pet in a kennel occasionally?
- ❑ Yes ❑ No Does your pet spend long periods of time home alone?
- ❑ Yes ❑ No Does your pet seem to have the same energy, stamina and strength as last year?
- ❑ Yes ❑ No Do you do anything for dental care? (please circle) Rawhide Chews Dental Food Brush Teeth
- ❑ Yes ❑ No Has your pet been to a different veterinarian since they were last here? If so, please describe:_____

_____

Please check any of the following that are a problem:

- ❑ Bad Breath
- ❑ Coughing/ Sneezing
- ❑ Vomitting
- ❑ Diarrhea/ Loose Stools
- ❑ Ear Infections/ Itchy Ears
- ❑ Housetraining/ Litterbox
- ❑ Itching/ Scratching too much
- ❑ Straying from home
- ❑ Biting
- ❑ Odor
- ❑ Difficulty getting up
- ❑ Excessive water consumption
- ❑ Limping
- ❑ Overweight
- ❑ Painful (location)_____

Please list any other concerns we may help you with_____