

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

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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 \_\_\_\_\_

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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 Questionnaire

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  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No

Do you take your pet to a groomer?  
Have you noticed a loss of hearing in your pet?  
Do you board your pet in a kennel occasionally?  
Does your pet spend long periods of time home alone?  
Does your pet seem to have the same energy, stamina and strength as last year?  
Do you do anything for dental care? (please circle) Rawhide Chews Dental Food Brush Teeth  
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:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bad Breath                 | <input type="checkbox"/> Houstraining/ Litterbox      | <input type="checkbox"/> Difficulty getting up       |
| <input type="checkbox"/> Coughing/ Sneezing         | <input type="checkbox"/> Itching/ Scratching too much | <input type="checkbox"/> Excessive water consumption |
| <input type="checkbox"/> Vomitting                  | <input type="checkbox"/> Straying from home           | <input type="checkbox"/> Limping                     |
| <input type="checkbox"/> Diarrhea/ Loose Stools     | <input type="checkbox"/> Biting                       | <input type="checkbox"/> Overweight                  |
| <input type="checkbox"/> Ear Infections/ Itchy Ears | <input type="checkbox"/> Odor                         | <input type="checkbox"/> Painful (location) _____    |

Please list any other concerns we may help you with \_\_\_\_\_