



PATIENT HISTORY FORM

Client's Name _____ Patient's Name _____

Reason for visit _____

Date when symptoms started? _____

Phone number where you can be reached: _____

Check all that apply:

- | | | |
|--------------------|------------------------|-------------------------|
| Normal/No Concerns | Blood in Stool | Vomiting |
| Weight Loss | Coughing/Gagging | Abnormal Urination |
| Diarrhea | Seizures | Drinking Excessively |
| Scotting | Breathing Difficulties | Check ear L R |
| Increased Appetite | Lethargic | Check eye L R |
| Decreased Appetite | Sneezing | |

Skin Growth/Lump-where? _____

Scratching/Rash-where? _____

Limping-which leg? Right Front Left Front Right Rear Left Rear

 Indoor Pet Outdoor Pet Both Indoor/Outdoor Pet

Please give us any information about your pet that can assist us:

Pet Food Brand? _____ How much? _____

Is your pet on preventative? Heartworm Flea Tick

Vaccines Information (When/Where)? _____

Any previous medical conditions? _____

Is your pet on any medications or supplements? _____

Refills Needed: Yes No

VCA Park Cities Animal Hospital

4365 Lovers Lane • Dallas, Texas 75252 • 214-368-8573 • vcaparkcities@vca.com



AT VCA ANIMAL HOSPITALS, WE CARE