PATIENT HISTORY FORM

EMAIL TO US
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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
- ☐ Weight Loss
- ☐ Diarrhea
- ☐ Scooting
- ☐ Increased Appetite
- ☐ Decreased Appetite
- ☐ Blood in Stool
- ☐ Coughing/Gagging
- ☐ Seizures
- ☐ Breathing Difficulties
- ☐ Lethargic
- ☐ Sneezing
- ☐ Vomiting
- ☐ Abnormal Urination
- ☐ Drinking Excessively
- ☐ Check ear ☐ L ☐ R
- ☐ Check eye ☐ L ☐ R

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 Westside Animal Hospital

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