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CARDIOLOGY PATIENT HISTORY FORM

6995 East Kemper Rd. • Cincinnati, OH 45249 • P: 513.530.0911 • F: 513.530.0811
6405 Clio Rd. • Centerville, OH 45459 • P: 937.428.0911 • F: 937.428.6667

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Name: _____ Date: _____

1. Is your pet coughing? ☐ YES ☐ NO

2. If yes, describe it. (choose all that apply)

☐ harsh ☐ honking ☐ wheezing ☐ soft ☐ wet ☐ ends with vomit ☐ ends with gag

How many episodes in one day? _____

3. When does the cough usually occur? (choose all that apply)

☐ at night ☐ in the morning ☐ after activity/excitement ☐ anytime

4. Is your pet eating and drinking normally? ☐ YES ☐ NO

If no, please describe _____

5. What food and/or treats does your pet usually eat?

6. Is your pet urinating and defecating normally? ☐ YES ☐ NO

If no, please describe _____

7. Has your pet had a recent change in activity level? ☐ YES ☐ NO

If yes, please describe _____

8. Has your pet collapsed at home? ☐ YES ☐ NO – If Yes, briefly describe the collapse event:

- Did it occur during or after activity?
- Did it occur at rest?
- Was your pet limp or stiff?
- Was your pet on their side, abdomen, or back?
- Were they trembling, tremoring, or shaking?
- How long did the episode last approximately?
- Was your pet acting normally immediately afterward?
- How long until your pet appears normal?

9. Does your pet have any other medical problems (such as diabetes, arthritis, etc.)? ☐ YES ☐ NO

10. Is your pet having any difficulty or rapid breathing? ☐ YES ☐ NO

11. Please list any medications and dosages that your pet is taking:

12. Is your pet sleeping well through the night? ☐ YES ☐ NO

13. What position does your pet sleep in? (on back, curled-up, etc.) _____

14. Has this changed recently? ☐ YES ☐ NO