



# PATIENT HISTORY FORM

Client's Name \_\_\_\_\_ Patient's Name \_\_\_\_\_

Surgery(s) to be performed: \_\_\_\_\_

Phone number where you can be reached: \_\_\_\_\_

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

Date and Time your pet last ate: \_\_\_\_\_

Is your pet on preventative?       Heartworm     Flea       Tick

Vaccines Information (When/Where)? \_\_\_\_\_

Is your pet micro-chipped? If yes, micro-chip #: \_\_\_\_\_

Is your pet female? If yes, last heat cycle and/or litter: \_\_\_\_\_

Any previous medical conditions? \_\_\_\_\_

Allergies? If yes, please list the allergies and when and what medication was given:

Is your pet on any medications or supplements? If yes, please list when and what medication was given: \_\_\_\_\_

**Check all that apply:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Normal/No Concerns     | <input type="checkbox"/> Coughing/Gagging     | <input type="checkbox"/> Vomiting       |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Weight loss    |
| <input type="checkbox"/> Sneezing               | <input type="checkbox"/> Abnormal Urination   | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Increased Appetite     | <input type="checkbox"/> Drinking Excessively | <input type="checkbox"/> Diarrhea       |
| <input type="checkbox"/> Decreased Appetite     | <input type="checkbox"/> Lethargic            | <input type="checkbox"/> Scooting       |





# CPR CONSENT FORM

## Consent to perform exam:

Please help us to help your pet by making some difficult decisions in advance. In the event of cardiac or respiratory emergency we will make every effort to notify you immediately, but also must take immediate medical action. Should my pet identified above require cardiopulmonary resuscitation (CPR), including cardiac compression, positive pressure ventilation, emergency drugs, or other medically necessary interventions, I request that the doctor(s) at VCA Park Cities Animal Hospital pursue such medical care as indicated below.

Please initial **ONE** of the authorizations listed below.

## Resuscitation Status:

I request CPR including artificial ventilation and external cardiac assistance (CPR). I am aware of the associated fees to have these services performed.

I accept that if the hospital staff is unable to reach me within 15 minutes after the initiation of CPR procedures, and after exercising reasonable medical judgment, determine that there appears to be virtually no hope for medical success, the staff will cease further CPR procedures. I acknowledge that CPR does not guarantee or assure a favorable outcome. I understand that despite the best efforts of the doctors and staff at this facility, even the most successful CPR that may restore my pet's life may not allow for my pet to regain his/her normal mental and physical health.

I hereby request that in the event my pet's heart and/or breathing should stop, no attempt will be made to resuscitate the pet.

***I have read and understand this consent form and verify that I am of legal age (18 years or older).***

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**VCA Park Cities Animal Hospital**

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**AT VCA ANIMAL HOSPITALS, WE CARE**