Patient/Client label here Date _____

Patient is Presented for: _____

1. Please list medications that your pet is currently taking and time last administered/applied. Please include topical medications.
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

Heartworm Prevention Brand Name_____ When last given_____

Flea/Tick Control Brand Name_____ When last given_____

3. Does your pet currently take any supplements? No____ Yes (list) _____
4. Is your pet allergic to any drugs/medication? No___ Yes (list) _____
5. Do you need any refills or diet pickups today? No___ Yes (list) _____
6. What is your pet's diet?

   Wet___ Brand/Formula _____Amount_____Frequency_____

   Dry___ Brand/Formula _____Amount_____ Frequency_____

   Treats _____

   People food (cooked/raw)_____

   Last time fed? _____
7. Any injury or illness in the past 30 days? No ___ Yes _____
8. Any history of seizures? No ___ Yes (frequency) _____

1) 9. Has your pet experienced any of the following changes or problems:

a) Appetite Increase	No ___Yes ___	Weight gain	No ___Yes ___
Appetite Decrease	No ___ Yes___	Weight loss	No ___Yes ___
Increased thirst	No___ Yes ___	Increased urination	No ___Yes ___
Decreased thirst	No ___Yes ___	Decreased urination	No___ Yes ___
Breathing difficulty	No ___ Yes ___	Coughing	No ___ Yes___
Sneezing	No ___ Yes ___	Vomiting	No ___ Yes ___
Diarrhea	No ___ Yes ___	Constipation	No ___ Yes ___
Bad Breath	No ___ Yes ___	Drooling	No ___ Yes ___
Shaking head	No ___ Yes ___	Rub/scratch ears	No ___ Yes ___
Scratching skin	No ___ Yes ___	Hair Loss	No___ Yes ___
Licking feet/other	No ___ Yes ___	Weakness	No ___ Yes ___

Difficulty rising No ___ Yes ___ Stiffness No ___ Yes ____

Falling down No ___ Yes ___ Please describe _____

Lameness No ___ Yes ___ Leg affected _____

Rubbing eyes/ squinting / blinking (circle all or any if affected). Which eye? Right/Left/Both

Runny eyes No ___ Yes ___ Color of discharge _____

New Lumps No __- Yes ___ Where _____

10. Has your pet exhibited any of the following changes in behavior?

    Urination out of litter box (cats/small dogs)/in the house (dogs) No ___ Yes ___

    Defecation out of litter box (cats/small dogs)/in the house (dogs) No ___ Yes ___

    Circling No ____ Yes ____ Toward which side _____

    Head tilt No ____ Yes ____ Toward which side _____

    Other/describe _____

11. Has your pet:

    Boarded/daycare within the last 28 days? No ___ Yes ___

    Gone to dog parks/dog shows/been in the same room with another dog that is not your own in the last 28 days? No ___ Yes ___

    Traveled? No ____ Yes ____ From Where? _____

    Been exposed to a new (within the last 28 days) foster cat/dog? No ___ Yes ___

If presenting for an illness, please describe in further detail with chronology of progression:

_____

_____

_____

_____

Do you have any other questions, concerns, or requests?

_____

_____

_____

_____

Phone Number #1_____Phone Number #2_____

How do you prefer to be contacted? Call ___ Text ____ Please be available for contact during your pet's appointment

I do hereby give my permission to a VCA South Arundel Animal Hospital Veterinarian to examine my pet, as listed above. No treatments will be initiated without review of a treatment plan and my approval.

Printed name: _____Signature: _____ Date:_____

Technician to complete in exam room (initial____):

Weight:_____ **Temp:_____**