Patient/Client label here   Date ____________________

NEW PUPPY/KITTEN FORM

Patient name: ___________________

Patient is presented for: ____

1. Are you interested in signing up for our Care Club Wellness Plan today? Yes___ No____ More info please____
2. Please list medications that your pet is currently taking and time last administered/applied. Please include topical medications.
   a. ____
   b. ____
   c. ____

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

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/pads (kittens/puppies)/in the house (dogs) No ___ Yes ___

Defecation out of litter box/pads (kittens/puppies)/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) cat/dog/other pet in household? No ___ Yes ___

12. Does your kitten/puppy:

Claw/scratch furniture No___ Yes___

Use the litterbox (kitten) No___ Yes___

Use puppy pads No___ Yes___

Go potty outside No___ Yes___

Crate train No___ Yes___

Play bite or scratch No___ Yes ___

Destroy property No___ Yes___

Leash walk No___ Yes___ (Collar or Harness?)

Respond to commands (check all that apply):

Sit __ Stay__ Lay down__ Shake__ Wait___ Other________________

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:** ________