Patient Medical History

Client Name: _____ Patient Name: _____

Diet: _____ Last Meal: _____AM / PM

Please list all medications or supplements your pet is taking:

Medication / Supplement	Dose	Time Last Dose Given

For patients receiving an anesthetic: Has your pet received their Comfort Pack (Cerenia & Gabapentin)?
Yes / No If yes, when was it given? _____

Any prior reactions/allergies to medications or vaccinations? Yes / No
If yes, please describe: _____

Has your pet shown recent signs of illness such as vomiting, diarrhea, coughing or sneezing? Yes / No
If yes, please describe: _____

Has your pet shown changes in appetite, drinking or exercise habits? Yes / No
If yes, please describe: _____

Please list any other concerns about your pet: _____

_____

_____

Please list any belongings left with your pet *(The clinic will not be responsible for lost items.):* _____

_____

For dogs and cats, please list the type and latest dose of flea medication provided to your pet:

Type: _____ Date Given: _____

Please list any behavioral or handling concerns *(fear biting, dog aggression, pain, etc.)*: _____

_____

_____

The information provided on this form is true to the best of my knowledge. I also accept that if evidence of live fleas is found on my pet that a dose of flea medication will be given to my pet at a cost not to exceed $26. (This policy protects your pet as well as others in the clinic.)

Client signature _____ **Date** _____

{OFFICE USE ONLY} Technician/DVM Witness (initials) _____