**Oncology Department Patient History Form**

Please complete this form to the best of your knowledge. Thank you!

Owner Name Patient Name

Problem/Complaint

Is your pet up-to-date on vaccines? Yes No

Recent treatments for current problem

Current Medications:

1. Dose How often Last given

2. Dose How often Last given

3. Dose How often Last given

4. Dose How often Last given

What are you feeding your pet? Please include any supplements, vitamins, or herbs

Any known allergies? If so please explain

Is it ok to give your pet treats during your appointment? (We’ve been known to give cookies to our patients☺)

In recent history have you noticed any changes in…(Please circle what applies)

Drinking: (Increased/Decreased/Normal) Appetite: (Increased/Decreased/Normal)

Weight: (Increased/Decreased/Normal) Energy: (Increased/Decreased/Normal)

Urination: (Increased/Decreased/Normal) Defecation: (Increased/Decreased/Normal)

Coughing: (Increased/Decreased/Normal) Pain/Lameness: (Increased/Decreased/Normal)

Vomiting: (Yes/No) If yes, how often?

Other comments