Patient History

Animal Medical Center of Seattle

Pet's Name: _____
Owners Name: _____
Date: _____
Time: _____

Problem / Complaint: _____
When did this problem start? _____

Has your pet been treated for any medical or surgical problems previous to this visit? _____
If yes, describe _____
How long have you owned your pet? _____
Are there other pets in the household? _____

Is your pet: female / male? spayed / neutered? yes / no
If not spayed, when was her last heat? _____ Is she pregnant? yes / no

When was your pet last vaccinated against viral disease? _____ Rabies? _____
Cats only: Has your cat been tested for FELV / FIV? yes / no Results? _____

Is your pet currently receiving any medications to prevent heartworm / fleas / ticks? _____
Please list type of medication used: _____

Is your pet indoor / outdoor / both? _____ If outside, are they supervised? yes / no
Do they have neighborhood access? yes / no

Has your pet had access to raw fish? yes / no Access to garbage? yes / no

What kind of food does your pet normally eat? _____
Access to table scraps or meat bones? yes / no If yes, please specify _____

Is your pet currently taking any medications? yes / no
If yes, please list(please include any pain medications, vitamins / supplements):_____
_____

Has your pet ever had a reaction to or side effects from a medication? yes / no
If yes, please list: _____

Has your pet ever had a seizure? yes / no

Please turn over and complete page 2

Date _____ Pet's Name _____

The following questions are based on the last 24 - 48 hours

Has there been any change to your pet's energy level or behavior recently? yes / no
If yes, please describe: _____
_____

Has there been an increase or decrease in your pet's appetite recently? (circle one if applicable)

Has there been an increase or decrease in your pet's water intake recently? (circle one if applicable)

Has your pet had any vomiting? yes / no
When did it start? _____
How often, how much? _____

Has your pet defecated recently? yes / no When was the last normal stool? _____
Any diarrhea? yes / no Any straining? yes / no Any blood? yes / no

Does your pet have a history of urinary problems? yes / no
Is your pet urinating more frequently than normal? yes / no
Any straining to urinate? yes / no
Any blood in the urine or discoloration? yes / no

Is your pet coughing? yes / no When did it start? _____
Describe _____

Is your pet sneezing? yes / no When did it start? _____
Is there any nasal discharge or bleeding? _____

Is your pet currently taking any medications? yes / no
If yes, please list (please include any pain medications, vitamins / supplements):_____
_____

Has your pet ever had a reaction to, or side effects from a medication? yes / no
If yes, please list: _____

Other comments/observations/notes:_____
_____
_____
_____
_____
_____