

## MEDICAL HISTORY/RISK ASSESSMENT

This form is intended to help bring to mind conditions or symptoms you may not have noticed or though important. Your answers will help our doctor's determine the best treatment plan for your pet.

Pet's Name:

Owner's Name:

Date:

Reason for Visit/Complaint:

Does your pet have a microchip? Yes  No

What do you feed your pet? How often?

Does your pet stay: Inside  Outside  Both  Do you take your pet to the park/trail? Yes  No

Does your pet travel with you out of the area? Yes  No  Does your pet board/get groomed? Yes  No

Please list any medications/supplements your pet is taking, including preventatives:

**Appetite** Normal  Decreased  Increased

**Water Intake** Normal  Decreased  Increased

**Urination** Normal  Decreased  Increased

**Activity** Normal  Decreased  Increased

**Mobility** Normal  Decreased  Inability to: Stand  Jump Up  Run  Other

**Behavior:** Normal  Abnormal  Describe

**Pain Level:** 1-10(most painful) Where?

**Coughing** No  Yes  Frequency

**Sneezing** No  Yes  Frequency

**Vomiting** No  Yes  Frequency

**Diarrhea** No  Yes  Frequency

**Itching** No  Yes  Frequency

**Scotting** No  Yes  Frequency

**Eyes:** No problem  Vision Loss  Cloudy  Drainage  Rubbing  Other:

**Ears:** No problem  Shaking Head  Scratching  Odor  Seems Painful  Hearing Loss   
Other:

**Skin:** No Problem  Scratching  Rash  Bumps/Lumps  Hair Loss  Odor

Vaccination Status: Current  Needed

Previous Problems/Treatments/Surgery:

Prescription Refills/Diets Needed Today: