

CANINE MEDICAL HISTORY FORM

Owner: _____	Date: _____	
Pet Name: _____	Breed: _____	
Color: _____	Age / Birthdate: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> Neutered <input type="checkbox"/> F <input type="checkbox"/> Spayed

ABOUT YOUR DOG

1. Your dog was obtained from: <input type="checkbox"/> Breeder <input type="checkbox"/> Pet store <input type="checkbox"/> Friend <input type="checkbox"/> Stray <input type="checkbox"/> Humane Soc. <input type="checkbox"/> Other	
2. Your dog is: <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor <input type="checkbox"/> Both	Number of dogs in household: _____
3. Brand of pet food: _____	<input type="checkbox"/> Canned <input type="checkbox"/> Dry
4. How is your dog's appetite: <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	
How is your dog's attitude: <input type="checkbox"/> Happy-Active-Normal <input type="checkbox"/> Depressed-Lethargic <input type="checkbox"/> Other: _____	
Is your dog drinking: <input type="checkbox"/> Normally <input type="checkbox"/> More <input type="checkbox"/> Less than usual.	
5. Do you notice any of the following: <input type="checkbox"/> Limping <input type="checkbox"/> Eye Discharge <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Sneezing	
<input type="checkbox"/> Coughing <input type="checkbox"/> Shaking head <input type="checkbox"/> Scooting <input type="checkbox"/> Scratching <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Lumps	
<input type="checkbox"/> Bad breath often <input type="checkbox"/> Weight loss <input type="checkbox"/> Lethargy / weakness <input type="checkbox"/> Seizures <input type="checkbox"/> Hair loss	
<input type="checkbox"/> Pain or straining when urinating / defecating:	

YOUR DOG'S MEDICAL HISTORY

1. Previous veterinary hospital: _____
May we request your records from their office? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> First visit to a veterinarian
2. Has your dog had the following in the last 12 months:
Physical examination: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
Dental examination and cleaning: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
Heartworm test: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
Fecal sample test: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
Blood testing for kidney & liver function: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
3. Has your dog been vaccinated for the following in the last 12 months:
Rabies: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
Canine Distemper: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
Lyme Disease: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
Canine Cough: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
4. Has your dog been dewormed in the last 12 months: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
5. Flea & tick preventative(s): _____ <input type="checkbox"/> Collar <input type="checkbox"/> None
6. Heartworm preventative: _____ <input type="checkbox"/> None
7. Are you familiar with geriatric care for dogs over 7 years of age: <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Current medications and allergies:

COMMENTS: _____

