Pet History Form

Reason for Visit_____

Other past illnesses and injuries_____

Date of onset of current condition_____

What areas of the body are affected?_____

Condition is: Stable Worsening Improving Waxes/Wanes

Pet lives: Inside Outside On Leash only

Do your other pets have similar problems? Yes No N/A

Does your pet itch (scratching, rubbing, licking, biting)? Yes No

Level of itch: Mild Moderate Severe

Does your pet wake up at night itching or licking? Yes No

Do they prefer to sleep in places that are: Warm or Cool

Are the symptoms: Seasonal Non-Seasonal Unknown

Worst time of year? Winter Spring Summer Fall

Is your pet: scratching the ears, shaking the head, have odor or discharge from the ears

Does your pet have discharge from the eyes? Yes No

Circle any other symptoms: coughing, sneezing, vomiting, diarrhea, lack of appetite, weight loss, weight gain, excessive drinking, excessive urination, fatigue / lethargy, behavioral changes

Does your pet have a sensitive stomach? Yes No

Has a food trial been done? Yes No Which food?_____ Length_____

Current Diet_____Treats_____

List any known food or drug sensitivity_____

List current and past medications Dosage Result

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