



Medical History Form

Pets Name (first and last): _____

Date: _____

Medications and Supplements

I Give the Following Medication/Supplement:

Strength:

How often:

My pet's diet:

Brand Name

How Much

How often

Dry _____

Wet _____

Treats _____

In the event that your pet runs out of food, are we authorized to feed our house food (Fromm All Natural Adult Formula)? No Yes

Does your pet have any allergies to food? No Yes If yes, please list _____

My pet (lifestyle):

Remains Indoors Only

Goes Indoor & Outdoor

Lives Strictly Outdoors

Hunts

Is Supervised When Outdoors

Boards at Kennel

Goes to Daycare



Medical History Form

Bumps, Growths or Masses

My pet has a bump, growth, or mass that has not been seen by a veterinarian before: No Yes

It is located: _____

Have any of the above been diagnosed by a veterinarian? No Yes

What was the diagnosis? _____

Does Your pet have a history of the following:

- | | | | | |
|---------------------------------------|-------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Weight Change |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Gagging | <input type="checkbox"/> Weakness | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Appetite Change |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tremors | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Pain | <input type="checkbox"/> Increased Panting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Confusion | <input type="checkbox"/> Eye discharge | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Breathing Changes |
| <input type="checkbox"/> Hairballs | <input type="checkbox"/> Seizures | <input type="checkbox"/> Odor | <input type="checkbox"/> Depressed | <input type="checkbox"/> Frequently Urinates |
| <input type="checkbox"/> Vocalization | <input type="checkbox"/> Scratching | <input type="checkbox"/> Aggression | <input type="checkbox"/> Biting | <input type="checkbox"/> House Soiling |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Drooling | <input type="checkbox"/> Tooth Loss | <input type="checkbox"/> Dull Coat | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Matted fur | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Constipation | <input type="checkbox"/> Drinks Excessively |
| <input type="checkbox"/> Sore Gums | <input type="checkbox"/> Overweight | <input type="checkbox"/> Underweight | <input type="checkbox"/> Grooms Less | <input type="checkbox"/> Urinates Large Amount |
-
- Skin allergies
- Diabetes
- Cancer
- Urinary Tract Infections
- Heart disease
- Breathing Problems
- Arthritis