ACRES NORTH
ANIMAL CLINIC

PET MEDICAL HISTORY QUESTIONNAIRE

DATE:
OWNER:
PATIENT NAME:

PLEASE ANSWER EACH QUESTION BELOW			IF YES, HOW LONG?
Is your pet coughing?	YES	NO	
Is your pet sneezing?	YES	NO	
Is your pet vomiting?	YES	NO	
Does your pet have diarrhea?	YES	NO	
Is your pet eating/drinking well?	YES	NO	
Is your pet urinating/defecating normally?	YES	NO	
Is your pet itchy/scratching/licking/ chewing excessively?	YES	NO	
Any new lumps/bumps or changes to existing lumps/bumps?	YES	NO	
Is your pet limping/having trouble getting around?	YES	NO	
Is your pet currently on heartworm, flea, or tick prevention?	YES	NO	If yes, when was the last dose given and what brand/type:
Is your pet currently on any medications?	YES	NO	If yes, please list the medication(s):
What food does your pet currently eat?	DRY	WET	Please name the brand/type: