History Form - Canine & Feline - *Initial or Annual Exam*

Willard Veterinary Clinic

_____ _____ _____ _____ _____

Date Client name Pet Name Species Acct. #

Initial Exam: Source: Breeder, Pet Store, Shelter, Stray, Other_____ Date obtained: _____
Approximate age when obtained: _____ Number of previous owners: _____
Any prior veterinary exam, or since last visit here? ☐ No ☐ Yes, Date: _____ Hospital Name:_____
*Reason for visit:*_____
Previous Vaccinations: (when & where) _____

Main reason for visit: _____
_____

How long have any problems been noted? _____
Diet Fed: Brand of dry and/or canned: _____
Amount_____ Frequency_____ Table food_____ Treats_____
Body Weight: ☐ no change ☐ weight loss ☐ weight gain **Diet changes since last visit:** ☐ No ☐ Yes
Appetite: ☐ normal ☐ increased ☐ decreased **My pet last ate:**_____ (am / pm)
Drinking: ☐ normal ☐ increased ☐ decreased
Attitude/Activity: ☐ normal ☐ increased ☐ decreased
Medications/Flea/Tick/Heartworm/ Supplements Yes ☐ No ☐ Please list what you are giving, the frequency & when last given.

Other Pets in household: ☐ No ☐ Yes, List type & number_____
_____

Exercise & Travel: *-Indoors only, never outside:* ☐ Yes ☐ No *-Supervised at all times when outside:* ☐ No ☐ Yes
Out of state: ☐ No ☐ Yes, Locations visited or future plans:_____
Local/routine: ☐ Park ☐ Neighborhood Walks ☐ Mountain Preserve ☐ Pet Store ☐ Other_____
Grooming/Bathing: ☐ **No** ☐ **Yes** ☐ *self* ☐ *professional groomer* frequency:_____
Boarding/Daycare: ☐ No ☐ Yes, Location_____ frequency:_____
Home Dental Care: ☐ No ☐ Yes, Type_____
Dental problems noted: ☐ No ☐ Yes: ☐ bad breath ☐ tartar ☐ toothloss ☐ other:
Pain: ☐ No ☐ Yes ☐ mild ☐ moderate ☐ severe Location:
Limping: ☐ No ☐ Yes, Location & when noted:
Difficulty rising/stiffness: ☐ No ☐ Yes When noted:
Seizures: ☐ No ☐ Yes, age first started, frequency, duration: _____
Urination: ☐ normal ☐ abnormal ☐ *More Volume* ☐ *More Frequent* ☐ *Straining* ☐ *Leaking* ☐ *Blood* ☐ *Marking*
Feces (stool): ☐ normal ☐ abnormal, ☐ *too firm/dry* ☐ *soft* ☐ *diarrhea* ☐ *blood* ☐ *straining* ☐ *frequent* ☐ *worms*
Flatulence (gas): ☐ No ☐ Yes, Is this something you would like reduced? ☐ No ☐ Yes
Litter Box: ☐ No ☐ Yes (number of boxes:_____, type of litter_____)
Vomiting: ☐ No ☐ Yes, Frequency: _____ Describe:_____
Coughing: ☐ No ☐ Yes, Frequency: _____
Sneezing: ☐ No ☐ Yes, Frequency: _____
Breathing: *Select:* ☐ *normal* ☐ *increased effort* ☐ *panting more* ☐ *other*_____
Spayed/neutered: Yes: *Age when altered*_____ / No: *Last heat cycle:*_____ *Duration of heat cycle*_____
Allergies or negative vaccine reactions: ☐ No ☐ Yes,_____

Skin problems :

Scratching/Itching/Licking/Wounds: ☐ No ☐ Yes
Lumps/bumps/swellings: ☐ No ☐ Yes
Fleas or Ticks noted ☐ No ☐ Yes
Skin or Hair coat changes: ☐ No ☐ Yes
Scooting on bottom: ☐ No ☐ Yes

Eye:

Discharge, squinting, other: ☐ No ☐ Yes
Vision changes: ☐ No ☐ Yes

Ear:

Discharge, odor, shaking head: ☐ No ☐ Yes
Hearing loss: ☐ No ☐ Yes

Describe any noted as Yes above:_____
Behavioral concerns: ☐ No ☐ Yes, *Select:* ☐ *Excessive barking,* ☐ *property destruction,* ☐ *aggression,* ☐ *house soiling,* ☐ *marking,* ☐ *pacing/circling,* ☐ *eating feces,* ☐ *other* _____
Microchip or Tattoo? ☐ No ☐ Yes
Any other specific concerns?

Please email completed form to: willardvc@yourvetdoc.com