

**PATIENT HISTORY SHEET**

13085 Perry HIGHWAY WEXFORD, PA 15090

PHONE: 724-591-8393

email: [internalmedicine@shvh.vet](about:blank)

urgentcare@shvh.vet

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If feline: Indoor Outdoor Indoor & Outdoor

What are your concerns about your pet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional household pets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your pet last vaccinated?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled with your pet recently? If so, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list flea/tick/heartworm preventive. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional medical history, including surgeries, allergies, and special needs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current** medications:

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D**iscontinued or completed** medications:

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Response:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your pet exhibited any of the following? (Please circle all that apply)

* Lethargy Yes No
  + If yes: Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Change in water consumption Yes No
  + If yes:
    - Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Increase OR Decrease
* Change in urination Yes No
  + If yes:
    - Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Increase OR Decrease
    - Straining
    - Blood
* Changes in appetite Yes No
  + If yes:
    - Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Increase OR Decrease
      * If Decrease:
        + Interested in eating Yes No
        + Oral pain Yes No
* Vomiting Yes No
  + If yes:
    - Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Food OR Bile/ Saliva
    - Active OR Passive
    - Specific time of day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diarrhea Yes No
  + If yes:
    - Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Blood and/ or Mucus
    - Straining
    - Abnormal stool color
      * Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Sense of urgency
    - Watery
* Constipation Yes No
  + If yes: Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Weight loss Yes No
  + If yes:
    - Over what time period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Appetite is increased/ decreased/ unchanged
* Gagging/retching Yes No
* Coughing Yes No
* Sneezing Yes No
* Abnormal breathing Yes No
  + If yes:
    - Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Associated with activity or excitement
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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