

**PATIENT HISTORY SHEET**

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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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