

Email Address: _____

PET HEALTH HISTORY

Name of Pet _____ Dog Cat Other _____

Breed _____ Color _____ Birthdate _____

Male Neutered Female Spayed

Vaccination History (Date and type of last vaccinations) _____

Please check (✓) any symptoms or problems that you have noticed about your pet.

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirst and/or Urination Increased |
| <input type="checkbox"/> Breeding Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed | |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | |

Pet's current medications _____

Any long-term problems _____

Brands and types of food fed to animal _____

SECOND PET HEALTH HISTORY

Name of Pet _____ Dog Cat Other _____

Breed _____ Color _____ Birthdate _____

Male Neutered Female Spayed

Vaccination History (Date and type of last vaccinations) _____

Please check (✓) any symptoms or problems that you have noticed about your pet.

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Limping | <input type="checkbox"/> Thirst and/or Urination Increased |
| <input type="checkbox"/> Breeding Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed | |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> Shaking Head | |

Pet's current medications _____

Any long-term problems _____

Brands and types of food fed to animal _____