DOG, CAT OR FERRET HISTORY FORM

Patient Name: ___________________ Owner: ___________________ Date: ___________________

Breed/Type: ___________________ Primary Color: ___________________

- How long have you owned this pet? ______________________________________________________
- Where did you obtain this pet? (Pet Store, Breeder, Friend) ______________________________
- When/Where was your pet’s last wellness visit and vaccinations? __________________________
- Describe current activity level: □ Very active/athletic □ Normal □ Inactive □ Hyperactive
- Appetite is: □ Normal □ Decreased □ Excessive
- Water consumption: Amount/Thirst □ Normal □ Excessive □ Decreased
  Source □ Bowl □ Other (Creek, Toilet, Faucet, bottle, etc)
- Describe Housing Habits: □ Indoor/Outdoor □ Indoor Only □ Outdoor supervised/fenced yard
  □ Outdoor Only □ Allowed to Roam
- Describe typical diet (include brand-name, amount, table scraps): __________________________

Does your pet:
- ____ YES ____ NO Exhibit lameness or abnormal gait?
- ____ YES ____ NO Show changes in stamina or respiratory pattern/rate?
- ____ YES ____ NO Cough more than is normal? If yes, describe: ____________________________
- ____ YES ____ NO Have brown teeth, red gums, bad breath or broken teeth?
- ____ YES ____ NO Have redness or discharge from the eyes?
- ____ YES ____ NO Have painful, itchy, or smelly ears?
- ____ YES ____ NO Have itchy, scaly, or oily skin; hair loss?
- ____ YES ____ NO Have a history of chronic and/or recurring skin and/or ear problems?
  o Are they year round or seasonal? ___________________________________________________
  o Where on the body? ______________________________________________________________
- ____ YES ____ NO Have any undiagnosed or changes in skin lumps since last visits?
  o If yes, where? _________________________________________________________________
- ____ YES ____ NO Scoot or chew at their rear end?
- ____ YES ____ NO Have fleas or ticks? If not now, has had them recently?
- ____ YES ____ NO Any changes in urination (urine) or defecation (stools)?
- ____ YES ____ NO Vomit? How Often? ______ In what relation to eating? _____________
- ____ YES ____ NO Have behavioral concerns? ____ House Soiling ____ Aggression ____ Destructiveness
  ____ Phobias (Thunderstorm, Strangers, Loud Noises) ____ Separation Anxiety

- Please list any major past, chronic or ongoing medical problems: __________________________

- Please list current medications, vitamin/nutritional supplements, skin/ear/dental care products you use:

- Is your pet on heartworm preventive? □ Regularly □ Intermittently List Brand: _____________
- Is your pet on flea preventive? □ Regularly □ Intermittently List Brand: _________________

Thank you for choosing Westgate Pet and Bird Hospital