Healing Hands Animal Hospital

COMPREHENSIVE PET HEALTH HISTORY FORM

Client Name:____________________ Pet Name:_________________ Date:___________

What is the reason for your visit today? If pet is sick or injured please give a DETAILED description of the problem:	
When did the problem start?	
Is this a recurring issue?	Yes ☐ No ☐
Is the problem: The same ☐ Better ☐ Worse ☐	
Is your pet on heartworm prevention? What kind?	Yes ☐ No ☐
Is your pet on flea and tick prevention? What kind?	Yes ☐ No ☐
Has your pet been tested or treated for parasites in the last 6 months?	Yes ☐ No ☐
Have you seen worms in your pet's stool? If yes please describe the worms:	Yes ☐ No ☐
Is your pet currently on any medications? If yes please list the medications:	Yes ☐ No ☐
Is your pet allergic to any medications? If yes please list the medications:	Yes ☐ No ☐
Does your pet have a history of seizures?	Yes ☐ No ☐

Please check all that apply

Appetite
- ☐ Increased ☐ Decreased
- ☐ Not eating at all
- ☐ Increased water consumption
- ☐ Decreased water consumption
- ☐ Not drinking at all
- ☐ Vomiting ☐ Diarrhea
- ☐ Blood in stool
- ☐ Food intolerances

Weight: Increased ☐ Decreased ☐
Did pet eat this AM? Yes ☐ No ☐
Table scraps? Yes ☐ No ☐
Type of food:___________________
Amount:_______________________
Frequency:______________________
Type of treats if any: ______________

Coat and Skin
- ☐ Itching
- ☐ Wound/Laceration
- ☐ Sore/Hot Spot
- ☐ Dandruff
- ☐ Flakes
- ☐ Crust
- ☐ Hair Loss
- ☐ Red
- ☐ Swollen/Inflamed
- ☐ Unusual lumps/bumps
- ☐ Location(s):

____
____
____

Ears
- ☐ Both
- ☐ Right
- ☐ Left
- ☐ Odor
- ☐ Discharge
- ☐ Shaking Head
- ☐ Scatching Ears

Attitude
- ☐ Alert
- ☐ Lethargic
- ☐ Listless/Weakness
- ☐ Behavioral changes (if yes please describe):

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Eyes
- ☐ Both
- ☐ Right
- ☐ Left
- ☐ Red
- ☐ Swollen/Inflamed
- ☐ Squinting
- ☐ Scratching
- ☐ Discharge
- ☐ Cloudy
- ☐ Trouble Seeing

Nasal/ Chest
- ☐ Gagging
- ☐ Coughing
- ☐ Coughing Up: __________________
- ☐ Trouble Breathing
- ☐ Sneezing
- ☐ Nasal Discharge
- ☐ Color: ______________________

Back/ Abdomen
- ☐ Showing Pain
- ☐ Swelling
- ☐ Scooting
- ☐ Neck
- ☐ Back
- ☐ Abdomen
- ☐ Rectum

Urination
- ☐ Frequent urination
- ☐ Urinating less
- ☐ Not urinating
- ☐ Inappropriate urination
- ☐ Straining
- ☐ Blood in urine

Legs/Paws
- ☐ Right front
- ☐ Left front
- ☐ Right hind
- ☐ Left hind
- ☐ Limping
- ☐ Swollen
- ☐ Showing pain
- ☐ Not walking
- ☐ Stiffness/difficulty rising