Client _____ Patient _____ Patient's Age _____ Date _____

DROP-OFF APPOINTMENT:
COMPREHENSIVE PET HISTORY

Kelley ANIMAL HOSPITAL

Come. Heal. Stay *well.*

Please Circle Your Answers

Are your address and phone number still correct? Yes No

If no, please list changes _____

Reason for visit _____

When did this problem start? _____

Has your pet been seen for the same condition recently? Yes No

Are vaccinations up to date? Yes No

Any behavior changes? Yes No

If yes, please describe _____

Do you brush your pet's teeth? Yes No

Does your pet have bad breath? Yes No

Has your pet been tested for internal parasites within the past six months? Yes No

Is your pet on heartworm preventative? Yes No

Is your pet on flea control? Yes No

Does your pet have a history of seizures? Yes No

Is your pet currently on any medications? Yes No

If yes, please list _____

Is your pet allergic to any drugs/vaccinations? Yes No

If yes, please list _____

Diet/Treats _____

How much do you feed your pet daily? _____

Does your pet have any food intolerances? Yes No

If yes, please list _____

Did your pet eat this morning? Yes No

Appetite	Normal	Increased	Decreased
Weight	Stable	Gain	Loss
Water Consumption	Normal	Increased	Decreased
Bowel Movements	Normal	Constipated	Diarrhea
	How Long? _____		
Urination	Normal	Increased Amount	
	Straining	Increased Frequency	

Please Circle Your Answers

Does your pet have any of the following?

Vomiting	Yes	No
Coughing	Yes	No
Sneezing	Yes	No
Gagging	Yes	No
Stiffness	Yes	No
Lameness	Yes	No
Weakness	Yes	No
Listlessness	Yes	No
Hair Loss	Yes	No
Scratching	Yes	No
Shaking Head	Yes	No
Scooting	Yes	No
Lumps or Discharge	Yes	No

If yes to any of the above, please describe frequency & character

_____

_____

_____

Anything else we need to know?

_____

_____

_____

Do you want any of the following procedures performed?

Ears Cleaned	Yes	No
Anal Glands Expressed	Yes	No
Nails Trimmed	Yes	No