



FOUR SEASONS
ANIMAL HOSPITAL

Patient Medical History Questionnaire

Patient Name: _____ **Owner Name:** _____
Date: _____ **Email Address:** _____

What are we seeing your pet for today?

What are your expectations for this visit?

Lifestyle

1a. How long have you owned your pet?

1b. Where was your pet obtained?

1c. Has your pet ever lived or traveled out of the Bay Area?
If yes, when and where?

1d. Is your pet kept: Indoors Outdoors Both

1e. Are there any other animals in your household?
If yes, what other pets? Yes No

Are any other pets showing similar signs? Yes No

Diet

2a. What do you feed your pet (brand, formula, home cooked ingredients)?

2b. How much do you feed your pet per meal?

2c. How many meals do you feed per day?

2d. Is your pet ever fed any treats including table scraps?
If yes, what types? How often? Yes No

2e. Has there been any change in type of food or treats recently? Yes No

2f. Has your pet's appetite changed recently? No Increased Decreased

2g. Has your pet been drinking more water than usual? Yes No

Reproductive

3a. Has your pet been spayed or neutered?
If yes, at what age? Yes No

3b. Is your pet a show dog or a breeder? Yes No

3c. Other than spay or neuter, has your pet ever undergone anesthesia, surgery, or dentistry?
If yes, what and when?
Any complications? Yes No

3d. If an un-spayed female, when was her last heat?

3e. If female, has she had any litters? Yes No
If yes, when?
Any complications?

Gastrointestinal

4a. Has your pet had any diarrhea or abnormal stools recently? Yes No

4b. Has your pet had any vomiting or regurgitation recently? Yes No
If yes to any gastrointestinal problem, please explain:

Respiratory

5a. Has your pet been coughing? Yes No

5b. Has your pet had any nasal discharge? Yes No

5c. Has your pet been sneezing? Yes No

5d. Has your pet been experiencing any breathing difficulty? Yes No
If yes to any respiratory problem, please explain:

Additional Information

6a. Has your pet been more lethargic or less interested in exercise? Yes No

6b. Has your pet had any change in attitude or behavior? Yes No

6c. Has your pet ever had a seizure? Yes No

6d. Has your pet ever fainted? Yes No

6e. Recently, has your pet... Lost Weight Gained Weight No Change

6f. Have you noticed any abdominal distension? Yes No

6g. Has your pet demonstrated any lameness? Yes No

6h. Does your pet have any new or changing masses? Yes No

6i. Has your pet been treated for any other medical problems (including skin, eye, ear, etc.)? Yes No
If yes, please explain:

Medications

7a. Has your pet had any unusual/unexpected reactions to medications or vaccines? Yes No
If yes, please explain:

7b. Please list any medications your pet is currently taking (including creams, drops, monthly flea, tick, and heartworm medications) and the times that they are normally administered. When was the last dose given?

Drug	Dose and frequency
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- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

7c. Other than above, is your pet taking any over-the-counter medications (including aspirin, Benadryl, etc)?
If yes, please list:

- 1.
- 2.
- 3.

7d. Is your pet currently taking any herbal supplements, nutraceuticals, vitamins or holistic medications?
If yes, please list:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

Vaccination History

Please note date of last vaccination or viral testing, or if unknown, indicate if they are up to date

For Dogs:

Rabies _____ DHPP (Distemper) _____ Bordetella (Kennel Cough) _____
Leptospirosis _____ Other _____

For Cats:

Rabies _____ FVRCP _____ FeLV (Leukemia) _____ FIV _____
Other _____

Do you have any other concerns that we have not addressed?