



PET HISTORY

Please fill out the answers and be as descriptive as possible.

Pet's Name: _____ **Client's Name:** _____

Pet's Origin: ☐ Shelter ☐ Pet Store ☐ Breeder ☐ Stray ☐ Rescue ☐ Other **Weight:** _____

Pet's Personality: _____

Check all that apply

Interactions:

☐ Bossy ☐ Very Friendly ☐ OK w/all ☐ OK/aloof ☐ Shy/timid ☐ Confident ☐ Affectionate

Strangers:

☐ Barks/attacks ☐ Wags tail ☐ Slow rxn ☐ Oblivious ☐ Runs away

Patience:

☐ No ☐ yes ☐ Sometimes

Excitability:

☐ Yes ☐ Easily ☐ Slow ☐ No

Others:

- | | | |
|--|---|--|
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Watches all | <input type="checkbox"/> Symmetrical |
| <input type="checkbox"/> Vocal | <input type="checkbox"/> Loves petting | <input type="checkbox"/> Good coat |
| <input type="checkbox"/> Mellow | <input type="checkbox"/> Loves to eat | <input type="checkbox"/> Curious |
| <input type="checkbox"/> Follows rules | <input type="checkbox"/> Quiet | <input type="checkbox"/> Self contained |
| <input type="checkbox"/> Insecure | <input type="checkbox"/> Leaks urine | <input type="checkbox"/> Meditative |
| <input type="checkbox"/> Bites | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Slow + consistent |
| <input type="checkbox"/> Hyper | <input type="checkbox"/> Control of Attention | |
| <input type="checkbox"/> Eager to please | <input type="checkbox"/> Sociable | |
| <input type="checkbox"/> Clean | <input type="checkbox"/> Knows what to expect | |
| <input type="checkbox"/> Fear biter | <input type="checkbox"/> Hides | |
| <input type="checkbox"/> Strong | <input type="checkbox"/> Round/ Lg | |
| <input type="checkbox"/> Athletic | <input type="checkbox"/> Careful | |
| <input type="checkbox"/> Couch P. | <input type="checkbox"/> Loyal | |
| <input type="checkbox"/> Disciplined | <input type="checkbox"/> Loves order | |

Diet (Be specific please): _____

How is the appetite? ☐ None ☐ Decreased ☐ Normal ☐ Increased

Has the appetite changed recently? If so, How? _____

Drinking Habits: ☐ Sips ☐ Normal ☐ Drinks excessively

Have there been any changes in thirst level? _____ If so, How? _____

Water Preference: ☐ Fresh/running ☐ Toilet bowl ☐ Pool ☐ Water bowl

Litter Type/Habits/Number of boxes and location: _____

Any Heartworm or Flea medication used? Brands? _____

Vaccine History (What and when): _____

Other pets in household (Please include breeds/sex/ages): _____

Lifestyle: ☐ Indoor ☐ Outdoor ☐ Both ☐ Regular exercise ☐ Couch Potato

Animal Exposure: ☐ Kennel ☐ Groomer ☐ Training/Play Groups ☐ Dog Park ☐ Travel

Pet Preferences: ☐ Warm places ☐ Cold Places ☐ Hard Places ☐ Soft Places

☐ Dry Food ☐ Moist Food ☐ People Food

☐ Massage/Brushing ☐ Petting ☐ Limited touch

☐ Human company ☐ Animal Company ☐ Loner ☐ Likes Children

Any Phobias? _____ If so, please explain: _____

Medical Problems: _____

Medications/Supplements (Please include dose and frequency): _____

Response to medications: _____

Allergies (Food/inhalant/medications,etc): _____

Major Problem (Reason for visit) Please be as detailed as possible: _____

Please describe bowel movements: frequency and form (diarrhea, constipation, etc): _____

Please describe urination: (normal, excessive, concentrated, dark, light, smelly, large or small amounts, etc): _____

Please check any areas of concern or change:

- | | |
|--|---|
| <input type="checkbox"/> Appetite | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Thirst | <input type="checkbox"/> Mammary Leakage |
| <input type="checkbox"/> Urination | <input type="checkbox"/> Ear odor/Discharge |
| <input type="checkbox"/> Feces | <input type="checkbox"/> Head Shaking |
| <input type="checkbox"/> Vomit | <input type="checkbox"/> Squinting |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Body Odor |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Lumps/Bumps |
| <input type="checkbox"/> Sneezng | <input type="checkbox"/> Attitude |
| <input type="checkbox"/> Nasal Discharge | |

Other: _____

Additional Comments: _____
