



New Patient Medical History Questionnaire

Please take a minute to completely fill out the questionnaire. The more we know about your pet, the better we can provide the best medical care.

Pet's name: _____ **Date:** _____

1. What is your primary concern about your pet today:

2. Is your pet current on vaccinations? Yes ___ No ___
3. Was food withheld for today's visit? Yes ___ No ___
4. What time was your pet last fed? _____
5. What food does your pet eat? _____
6. Are there any lumps or bumps on your pet? Yes ___ No ___
If Yes... Where? _____
7. Has there been a recent change in your pet's behavior? Yes ___ No ___
If Yes... Describe _____
8. Has your pet been treated for any previous medical conditions or surgery?
If Yes... When and for what? _____
9. Is your pet in pain? Yes ___ No ___
10. Has your pet been hospitalized recently? Yes ___ No ___
If Yes... When? _____ Where? _____
Reason: _____
11. Has your pet's activity level changed recently? Yes ___ No ___
If Yes... Has it increased or decreased? _____
12. Has your pet's appetite recently changed? Yes ___ No ___
If Yes... Has it increased, decreased, not eating at all? _____
13. Has your pet's weight changed recently? Yes ___ No ___
If Yes... Has it increased or decreased? _____
14. Has your pet's water intake changed recently?
If Yes... Has it increased or decreased? _____
15. Has your pet been vomiting recently? Yes ___ No ___
If Yes... Frequency: _____ per day/per week (please circle)
16. Has your pet's defecations changed recently? Yes ___ No ___
If Yes... Diarrhea, straining to defecate, blood in feces, mucus in feces? _____
17. Have your pet's urination habits changed recently? Yes ___ No ___
If Yes... Has it increased or decreased, straining to urinate, blood in urine? _____
18. How long have you owned your pet? _____
19. Where was your pet obtained? _____
20. Has your pet traveled out of Nebraska in the last 5 years? Yes ___ No ___

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Pet's name: _____ **Date:** _____

Is your pet on any current medications? Yes ___ No ___

If Yes...Please list current medications

Name of Drug	Strength (mg)	#of pills per dose	Frequency given	Last given

Additional comments:

Thank you for taking the time to fill out the questionnaire.

For Doctor/Tech use only

Wt: _____ lb/kg Temp: _____ HR: _____ RR: _____

CRT/MM: _____ Pulse: _____