SIRIUS
VETERINARY ORTHOPEDIC CENTER

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

New Patient Medical History Questionnaire

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: _____