Peak Patient History Form

Pet Name:_____ Owner Last Name:_____ Date:_____

What is your pet's current problem?_____
_____
_____
_____

When was your pet last normal?_____

Has your pet ever traveled outside of the state? Yes / No
If yes, please list other states/countries visited and when_____
_____
_____

Where did you obtain your pet (shelter/breeder/stray/other) and at what age?_____
_____

For feline patients, please select one: indoor only outdoor only indoor/outdoor

What do you feed your pet currently? Please be as specific as possible and include amount if known_____
_____

Other than the problem listed above, please list other current or past medical problems or surgeries:
_____
_____
_____
_____

Has your pet (if female) ever been pregnant in the past? Yes No Unsure
Has your pet had a transfusion of blood products in the past? Yes No Unsure

When was your pet last vaccinated?_____
Are vaccines up to date?_____

Do you use any flea, tick or heartworm preventative? Yes No
If yes, what product(s) do you use and when were they last given?_____
_____

Do you have other pets at home? Yes No
If yes, what species and how many?_____

Did your pet have any food today? Yes No

****Questions continue on the next page, please turn over****

Please list any current medications (including over the counter medications, nutritional supplements and herbal medications). Complete as much as possible, but if unknown leave blank.

Drug name	Dose	How Often Given	When Started	Given Today?
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Please list any other drugs given in the past month but not given currently:_____
_____
_____
_____

Has your pet exhibited any of the following signs?

Vomiting?	Yes	No
Diarrhea?	Yes	No
Increased sneezing?	Yes	No
Coughing?	Yes	No
Abnormal breathing?	Yes	No
Decreased activity?	Yes	No
Urination abnormalities?	Yes	No
Gagging/retching?	Yes	No
Weight loss?	Yes	No
Weight gain?	Yes	No
Seizures?	Yes	No
Limping?	Yes	No
Pain?	Yes	No

Please circle one of the following:

Appetite:	Decreased	Increased	Normal
Drinking:	Decreased	Increased	Normal
Urination amount:	Decreased	Increased	Normal
Frequency of urination:	Decreased	Increased	Normal

Thank you for bringing your pet to Peak Veterinary Referral Center