# 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

**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:**

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

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 check any areas of concern or change:

Appetite ☐ Thirst ☐ Urination ☐ Feces ☐ Vomit ☐ Breathing ☐ Coughing ☐ Sneezing ☐ Nasal Discharge ☐ Vaginal Discharge ☐ Mammary Leakage ☐ Runny Eyes ☐ Ear odor/discharge ☐ Head Shaking ☐ Squinting ☐ Body Odor ☐ Lumps/bumps ☐ Attitude ☐

Other: _____

Additional Comments: _____
_____
_____
_____
_____
_____
_____