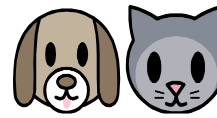
Patient Assessment Form



Pet's Name: ____ **Age**: _____________ **Date**: ______________________

Reason for visit: ____

Questions / Concerns / Behavior: ____

Prior medical history: ____

Previous lab testing: ____

Environment

Other Pets	Dogs#	Cats#	Other:			
Environment	Indoor	Outdoor	Indoor/outdoor	Screened lanai	Other:	
Activities	Boarding	Grooming	Dog park	Dog shows	Hunting	Other
Travel History	Florida only	Seasonal to:			Other:	

Does the pet have any of the following symptoms at home

Symptoms	Coughing	Sneezing	Eye discharge	Nasal discharge	Vomiting	Other:
Attitude	Normal	Disoriented	Depressed	Lethargic	Other:	
Weight	Stable	Increased	Decreased	Other:		
Appetite	Normal	Increased	Decreased	Other:		
Water Intake	Normal	Increased	Decreased	Other:		
Urination	Normal	Increased	Decreased	Straining	Blood	Accidents
Defecation	Normal	Mucous	Blood	Straining	Diarrhea	Constipation

Other symptoms: ____

Diet

Diet	(brand)			**Dry** (amount)		**Canned** (amount)
Treats	(brand)			**People food:**		
Dental Care	Brush Teeth	Oral Rinses	Oravet	Chews	Other:	

Parasite Prevention

Heartworm Prevention	Heartgard	Interceptor	Sentinel	Trifexis	Revolution
Last Applied	None	Other:			
Flea/Tick Prevention	Advantage	Frontline	Comfortis	Trifexis	Revolution
Last Applied	Preventic	Nexgard	None	Other:	

Please list ALL medications including supplements and doses you are giving:

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