



Internal Medicine – Patient Medical History

Please answer the following questions to the best of your ability.

Pet's Name:		
How long have you owned your pet?		
Where was your pet obtained?		
Is your pet: (circle one)		
INDOOR	OUTDOOR	BOTH
What does your pet eat?		
Approximately how much and how often does your pet eat?		
Prior to this illness, has your pet been treated for any major medical problems?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what type and when?		
Has your pet undergone any surgery?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what type of surgery and when?		
Is your pet receiving any medications?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what are they?		
Has your pet traveled outside of Colorado?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, where and when?		
What is your primary concern about your pet?		

Continued on back



Internal Medicine – Patient Medical History

Is your pet experiencing any of the following symptoms: (check all that apply)

Vomiting

Diarrhea

Sneezing

Increased Water intake

Increased Urination

Decreased Appetite

Difficulty Breathing

Nasal Discharge

Lethargy/ Decreased Energy

Coughing

Weight loss

Bleeding/Bruising

When did these symptoms begin?

Thank you for completing this form. A thorough medical history is essential if proper therapy is to be administered to your pet.