Patient Information and Medical History

200 Commerce St., Williston, VT 05495
Tel: 802.863.2387 Fax: 802.863.2348
www.bevsvt.com

Please check all appropriate choices and/or fill in information and add any information you feel is important.

Current Problem and Medical History

Client Name: _____ Pet's Name: _____ Date: _____
Why did you bring your pet in for a consultation? _____

_____

How long has your pet been sick? _____
List any medical problems or procedures that have occurred within the last two years: (include any surgery, trauma, etc…)

_____

General Information

How long have you owned your pet? _____
What is your pet's diet? ○ Canned ○ Dry Brand: _____ ○ Table Food
Are vaccinations current? ○ Yes ○ No
Has your pet traveled out of the state in the last six months? ○ Yes ○ No
Are there other pets in your household? ○ Yes ○ No Describe: _____

Current Medication

Heartworm Prevention: ○ Monthly Heartguard ○ Monthly Interceptor
Other Medications (describe): _____
Any unusual reactions to medications? ○ Yes ○ No Describe: _____

Changes in Normal Activity

Appetite: ○ No ○ Increased ○ Decreased Describe: _____
Water Intake: ○ No ○ Increased ○ Decreased Describe: _____
Weight: ○ No ○ Increased ○ Decreased Describe: _____
Urination: ○ No ○ Increased ○ Decreased ○ Straining ○ Blood in urine ○ Unusual odor to the urine
Describe: _____
Bowel Habits: ○ No ○ Increased ○ Decreased Describe: _____
Vomiting: ○ No ○ Daily ○ Weekly ○ Monthly ○ Intermittent Describe: _____
Coughing: ○ No ○ Daily ○ Weekly ○ Monthly ○ Intermittent Describe: _____
Sneezing: ○ No ○ Daily ○ Weekly ○ Monthly ○ Intermittent Describe: _____
Seizures: ○ No ○ Daily ○ Weekly ○ Monthly ○ Intermittent Describe: _____
Changes in walking: ○ No ○ Yes Describe: _____
Skin changes: ○ No ○ Itching ○ Yes Describe: _____
Swelling or tumors: ○ No ○ Yes Describe: _____
Vaginal discharge: ○ No ○ Yes Describe: _____
Any other changes? (describe): _____

If you wish to make any additional comments, please check the box and use the other side. ☐