

**PVSEC- Internal Medicine/Oncology**

**PATIENT HISTORY FORM**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

If feline:      Indoor          Outdoor          Indoor & Outdoor

What is your pet's current problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any other pets in the same household? If yes, what are they? \_\_\_\_\_  
\_\_\_\_\_

What do you currently feed your pet? \_\_\_\_\_

When was your pet last vaccinated? \_\_\_\_\_

Has your pet traveled in the past year? If so, where? \_\_\_\_\_

Are you currently using any flea/tick/heartworm preventive? If so, what brand? \_\_\_\_\_

Please list any previous health problems, including surgeries or allergies we should know about: \_\_\_\_\_  
\_\_\_\_\_

Is your pet on medications/supplements? If so, please list **current** medications.

Medication: \_\_\_\_\_ Dosage/frequency: \_\_\_\_\_ Response: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage/frequency: \_\_\_\_\_ Response: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage/frequency: \_\_\_\_\_ Response: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage/frequency: \_\_\_\_\_ Response: \_\_\_\_\_

Has your pet recently been on medications that are now **discontinued or completed**? If so, please list.

Medication: \_\_\_\_\_ Dosage/frequency: \_\_\_\_\_ Response: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage/frequency: \_\_\_\_\_ Response: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage/frequency: \_\_\_\_\_ Response: \_\_\_\_\_

**OVER→**

Has your pet exhibited any of the following? (Please circle all that apply)

- |                                       |       |             |           |             |
|---------------------------------------|-------|-------------|-----------|-------------|
| 1. Lethargy                           | Yes   | No          |           |             |
| 2. Drinking an abnormal volume        | Yes   | No          |           |             |
| 3. Frequent or difficult urination    | Yes   | No          |           |             |
| 4. Urinating an abnormal volume       | Yes   | No          |           |             |
| 5. Changes in appetite                | Yes   | No          |           |             |
| 6. Vomiting                           | Yes   | No          |           |             |
| 7. Diarrhea                           | Yes   | No          |           |             |
| If yes, please circle all that apply  | Blood | Clear Mucus | Straining | Black stool |
| 8. Constipation/difficulty defecating | Yes   | No          |           |             |
| 9. Recent weight loss                 | Yes   | No          |           |             |
| 10. Coughing                          | Yes   | No          |           |             |
| 11. Sneezing                          | Yes   | No          |           |             |
| 12. Abnormal breathing                | Yes   | No          |           |             |
| 13. Gagging/retching                  | Yes   | No          |           |             |

STAFF USE ONLY: T: \_\_\_\_\_ HR: \_\_\_\_\_ R: \_\_\_\_\_ mm/CRT: \_\_\_\_\_ Weight: \_\_\_\_\_ kg

Symptom Number	Characterize	Date of onset	Frequency	Progression	Response to therapy