



AIRPORT PET CLINIC - PATIENT HEALTH HISTORY FORM

Client: _____ Date: _____

An important part of the medical evaluation is an accurate history. Please take a few moments to complete this questionnaire. Please fill out 1 form for each pet that will be having an exam today. Do your best to answer all of the questions you can. The more information that we have, the better care we can provide for your pet. Additional information may be requested during consultation by the veterinarian.

Patient Name: _____ **Species:** Dog / Cat / _____ **Sex:** M F **Spayed/neutered?** Yes No
Age: _____ **Date of Birth (if known):** _____ **Breed:** _____ **Color/Markings** _____
Microchipped? No Yes, # _____

What is the primary reason(s) you are seeking veterinary medical attention for your pet today? _____

Vaccinations: Has your pet ever been vaccinated? No Yes; if yes, please provide/attach vaccine records.

Has your pet ever suffered a vaccine reaction in the past? No Yes (elaborate) _____

Environment:

My pet is exclusively indoor exclusively outdoor both indoor + outdoor

Are there any of the following environmental factors that your pet may be exposed to on a regular basis?

dust cigarette/cigar-smoke/vape-pens/e-cig foxtails rodents/squirrels/possum/other wildlife

Do you take your pet camping/hiking/fishing/boating? Yes No

Are there other pets in the house? No Yes (describe) _____

Are there young children present in the house? Yes No

Has your pet previously travelled? No Yes (describe) _____

How long has your pet resided in the current location? _____

Previous cities/states/countries, if applicable, of residence? _____

Flea/Tick/Heartworm/Deworming

Is your pet on flea/tick preventive? No Yes (brand?) _____

Is your pet on heartworm preventive? No Yes (brand?) _____

When was the last time your pet was dewormed? Never _____

Last heartworm test? Never _____ Was it negative? Yes No

For cats, has your cat ever had a leukemia/FIV test? No Yes, when? _____ Was it negative? Yes No

Grooming

When is the last time your pet was groomed? _____

What grooming facility do you frequent (if any)? _____

How often does your pet get a bath? _____ What shampoo do you use? _____

Do you routinely clean your pet's ears? No Yes; if yes, when? _____

Do you routinely trim your pet's nails? No Yes; if yes, when? _____

Dental

Do you brush your pet's teeth? No Yes; if yes, when? _____

Do you use dental products? No Yes; if yes, what brand? _____

Does your pet: suffer from bad breath drop food/drool difficulty eating chews on one side

Food:

Your pet's diet is predominately dry food wet/canned food human food combination

What brand of food? _____

What supplements/treats do you give your pet: _____

Does your pet get table scraps? Yes No

How often does your pet get treats once per day multiple times per day weekly monthly

Recently has your pet's appetite decreased increased stayed the same

What about your pet's water consumption? decreased increased stayed the same

When did your pet last eat? _____ Was it a normal amount? No Yes

Is there anything else we should know about your pet's diet? _____

Medications

Is your pet on any medications? No Yes; if yes please list them and the last time your pet has received a dose _____

Does your pet have any known allergies? _____

Has your pet ever experienced an adverse event or allergic reaction to medications and/or sedation/anesthesia? No

Yes; please elaborate _____

Labwork

Date of last bloodwork _____ My pet has never had bloodwork done

Date of last radiograph/x-ray _____ My pet has never had a x-ray

Date of last fecal analysis _____ My pet has never had a fecal analysis

Date of last urinalysis _____ My pet has never had an urinalysis

Last veterinary visit

This is my pet's first visit to a veterinary hospital/facility

This hospital

Another hospital. Please write the hospital/date/doctor/diagnosis and attach medical records.

Please check any signs/symptoms you have noticed recently about your pet:

- | | |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> lack of appetite |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> limping/stiffness |
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> breathing problems | <input type="checkbox"/> lumps/bumps |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> scooting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> scratching, score? _____ (1 to 10, 10 being really bad) |
| <input type="checkbox"/> Ear Issues | <input type="checkbox"/> seems depressed |
| <input type="checkbox"/> Eye Discharge/Swelling | <input type="checkbox"/> seizures |
| <input type="checkbox"/> Eyes bulging/bloodshot | <input type="checkbox"/> shaking head |
| <input type="checkbox"/> fainting | <input type="checkbox"/> spraying house/yard |
| <input type="checkbox"/> fleas/ticks | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> gagging | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> hair loss | <input type="checkbox"/> weakness |
| <input type="checkbox"/> increased thirst | <input type="checkbox"/> weight problems <input type="checkbox"/> increased <input type="checkbox"/> decreased |
| <input type="checkbox"/> increased urination | <input type="checkbox"/> other _____ |

Has your pet ever had a history of injury, trauma, or been diagnosed with a medical illness? No Yes, elaborate:

Temperament:

Describe your pet's normal temperament? _____

Does your pet go on car rides/trips frequently? No Yes

Do you find it difficult to get your pet into the carrier/car? No Yes, elaborate _____

How and where does your pet travel in the car? (carrier/seatbelt/loose/box/etc.) _____

During travel to the veterinary hospital, does your pet do any of the following:

- eager/excited reluctant hide drool vomit urinate/poop
 subdued bark/meow whine pant tremble pace other _____

Do you use any anxiety supplements/medications? No Yes; elaborate _____

Is your pet scared of: men women other dogs other cats uniforms _____

My pet prefers female veterinary staff male veterinary staff no preference/unknown

Has your pet ever exhibited aggressive tendencies towards other pets? No Yes

Has your pet ever exhibited aggressive tendencies towards people? No Yes

How would you describe your pet around other animals and people? _____

Does your pet have any sensitive areas that s/he does not like to have touched by you or others? _____

Are there any procedures that you have been told seem difficult to perform on your pet? (nail trims, weight, temperature, ear exam, blood draw, etc.) and elaborate on how your pet reacted _____

What is your pet's favorite toy(s); if any: _____

Check any situations below that your pet has shown avoidance or dislike of in the past.

- | | |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> entering the vet hospital | <input type="checkbox"/> going into the exam room |
| <input type="checkbox"/> other pets/people passing by in reception/lobby | <input type="checkbox"/> going into the treatment area |
| <input type="checkbox"/> waiting with other pets/people in reception/lobby | <input type="checkbox"/> sounds coming from the treatment area |
| <input type="checkbox"/> being approached by veterinary staff | <input type="checkbox"/> sounds of a clipper/shaver/trimmer |
| <input type="checkbox"/> getting on the scale for a weight | <input type="checkbox"/> being put up on an table for examination |
| <input type="checkbox"/> hearing the doorbell/intercom/phones ringing | <input type="checkbox"/> direct eye contact with veterinary personnel |
| <input type="checkbox"/> loud voices during examination | <input type="checkbox"/> having a rectal temperature taken |
| <input type="checkbox"/> use of a stethoscope | <input type="checkbox"/> use of otoscope (tool to look in ears) |

Anything else we need to know about your pet? _____

PAIN SCORE: please fill out the section that is applicable for your pet (i.e., dog or cat). Ignore the numbers in ().

DOGS

A. Observation – Is your dog normally:

- Quiet (0) crying/whimpering (1) groaning (2) screaming (3)

B. observe any wound or painful areas. If none, pick the first option (0)

- ignoring any wound or painful area (0) looking at wound or painful area (1)
 licking wound or painful area (2) rubbing wound or painful area (3)
 chewing wound or painful area (4)

C. When your dog walks normally, how is s/he?

- normal (0) lame (1) slow/reliuctant (2) stiff (3) refuses to move (4)

D. If it has a wound or painful area including abdomen, apply gentle pressure 2 inches around the site.

- no reaction (0) dog looks around (1) flinches (2)
 growl/guard area (3) snaps (4) cries (5)

E. How is your dog overall?

- happy/content or bouncy (0) quiet (1)
 indifferent or nonresponsive to surroundings (2) nervous/anxious/fearful (3)
 depressed or nonresponsive to stimuli (4)

F. Overall how is your dog?

- Comfortable (0) unsettled (1) restless (2) hunched/tense (3) rigid (4)

CATS

A. normally:

- cat is silent / purring / meowing 0
 Cat is crying / growling / groaning 1

B. normally:

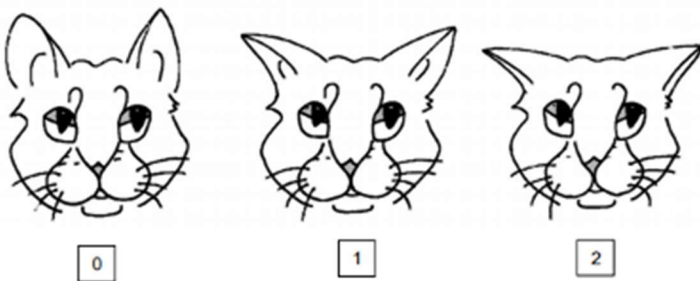
- cat is relaxed 0
 Licking lips 1
 Restless/cowering at back of cage 2
 Tense/crouched 3
 Rigid/hunched 4

C. if a wound is present:

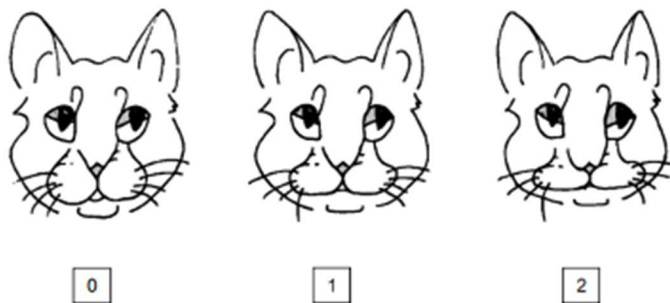
- cat is ignoring wound/painful area 0
 Cat is paying attention to wound 1

D&E:

a) Look at the following caricatures. Circle the drawing which best depicts the cat's ear position?



b) Look at the shape of the muzzle in the following caricatures. Circle the drawing which appears most like that of the cat?



F. call cat by name & stroke along back from head to tail

- Does cat respond to stroking 0
 Cat is unresponsive 1
 Cat is aggressive 2

G. if cat has a wound or painful area, apply gentle pressure 5 cm around the site. In the absence of any painful area apply similar pressure around hind leg above stifle.

- Cat does nothing 0
 Swishes tail/flatten ears 1
 Cat cries/hisses 2
 Growls 3
 Bite/lash out 4

H. general impression of cat

- Happy/content 0
 Disinterest/quiet 1
 Anxious/fearful 2
 Dull 3
 Depressed/grumpy 4