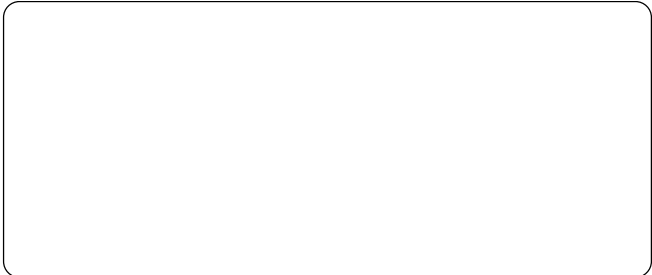




TEXAS A&M UNIVERSITY
 Veterinary Medical Teaching Hospital

Patient Information Worksheet



Directions: To aid the doctor in reaching an accurate diagnosis, a complete background on your pet is essential. Please fill out the following questionnaire to the best of your ability using a ballpoint pen. When you are finished, return the form to the receptionist.

How long have you owned your pet?			
Where was your pet obtained?			
Where is your pet primarily kept?	<input type="checkbox"/> Out of doors	<input type="checkbox"/> In the House	
Is your pet allowed to roam free?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has your pet been boarded or hospitalized recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Are there any other animals in your household? If yes, what?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has your pet's appetite either increased or decreased?	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Stayed the same
What time did your pet last eat?			
Has your pet lost or gained any weight recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
What is your pet's diet?			
How much and how often does your pet eat?			
Is your animal ever fed table food?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet been treated for any major medical problems? If yes, what?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If your pet is neutered, what was his/her age of alteration?			
Has your pet ever undergone surgery? If yes, what and when?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If female and not neutered, when was her last heat?			
Has your pet ever had any litters? If yes, when?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Is your pet now taking medication to prevent heartworm disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet traveled out-of-state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet lost any stamina lately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Is your pet drinking more water than usual?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Is your pet urinating more frequently than usual?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet vomited frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Have there been any recent changes in your pet's bowel movements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet been scratching?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet had any seizures or convulsions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet had any change in attitude or behaviors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Does your pet show any abnormal behaviors with thunderstorms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has there been a change in your pet's walking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Have you noticed any abnormal swellings? If yes, where?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet had any abnormal vaginal discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet had unusual/unexpected reactions to medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet had any discharge from the eyes or nose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Has your pet had any coughing or breathing difficulty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Does your pet show aggression towards people or other animals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does your pet bite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Please rate your pet's pain using a scale from 1 to 5.	<input type="checkbox"/> 1-No Pain	<input type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5-Maximum Pain
Vaccination History	Dog: Rabies _____	DHLPP _____	
	Cat: Rabies _____	FVRCP _____	FeLV _____ FIV _____ FIP _____

