

Your Pet's Medical History

**Valentine Veterinary House calls**

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**Conventional and Eastern Holistic Medical Options and Consultations**

**<Patient Label>**

**Name:**  
**Species:**  
**Breed:**  
**Sex:** **Altered: Y/ N**  
**DOB:**  
**Your name:**  
**Contact number(s):**  
**If applicable: please obtain medical records from:**  
**Hospital:**

**I. General Health**

- |                                 |                                   |   |   |
|---------------------------------|-----------------------------------|---|---|
| Your pet's activity level is    | <input type="checkbox"/> Normal   | <input type="checkbox"/> Increased            | <input type="checkbox"/> Decreased      |
| Your pet's water consumption is | <input type="checkbox"/> Normal   | <input type="checkbox"/> Increased            | <input type="checkbox"/> Decreased      |
| Your pet's appetite is          | <input type="checkbox"/> Normal   | <input type="checkbox"/> Increased            | <input type="checkbox"/> Decreased      |
| Your pet is breathing           | <input type="checkbox"/> Normally | <input type="checkbox"/> With more difficulty | <input type="checkbox"/> With more ease |
| Your pet is coughing            | <input type="checkbox"/> Yes      | <input type="checkbox"/> No                   |   |
| Your pet is sneezing            | <input type="checkbox"/> Yes      | <input type="checkbox"/> No                   |   |
| Your pet is vomiting            | <input type="checkbox"/> Yes      | <input type="checkbox"/> No                   |   |
| Your pet is defecating          | <input type="checkbox"/> Normal   | <input type="checkbox"/> Increased            | <input type="checkbox"/> Decreased      |
| Your pet is urinating           | <input type="checkbox"/> Normal   | <input type="checkbox"/> Increased            | <input type="checkbox"/> Decreased      |

**II. Adverse Reactions**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Your pet had adverse drug reactions in the past          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Your pet had adverse effects from sedation or anesthesia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Your pet has received blood transfusions                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**III. Your Pet's Environment**

- When did you get your pet? \_\_\_\_\_
- From where did you get your pet? \_\_\_\_\_
- What does your pet do? (Circle one)      Home Companion      Hunting dog      Sporting dog      Working dog
- What does your pet do during the day? \_\_\_\_\_
- What percentage does your pet spend outdoors? \_\_\_\_\_
- Do you have other pets?       Yes       No
- What type of pets?* \_\_\_\_\_
- How many?* \_\_\_\_\_
- Are they acting normally?*       Yes       No

**IV. Your Pet's Nutrition**

	Dry	Canned	Type	Amount per day
Hill's Science diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hill's Prescription diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
IAMS dog/cat food	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Eukanuba Veterinary Diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Purina dog/cat food	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Purina Veterinary Diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____



Leptospirosis 2 Serovars \_\_\_\_\_

Other: \_\_\_\_\_

Cat

**Vaccine**

**Date Received**

FeLV (feline leukemia) \_\_\_\_\_

FIP \_\_\_\_\_

FVRCP Intranasal \_\_\_\_\_

FVRCP Parenteral \_\_\_\_\_

Rabies, 1 yr. duration \_\_\_\_\_

**Vaccine**

**Date Received**

Rabies, 3yr. duration \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

**Infectious Disease Testing**

Has your cat been previously tested for FeLV?  Yes  No

Date: \_\_\_\_\_  Positive  Negative

Has your cat been previously tested for FIV?  Yes  No

Date: \_\_\_\_\_  Positive  Negative

Has your dog been tested for any tick-borne diseases? If so, which, and what were results?

Other infectious disease testing:

**Illnesses, Medications, and Disease History:**

Pet has been diagnosed with:

Current medications (name/amount/frequency):

Duration (months/yrs.):

Do you feel that the medication(s) are helping  100%  75%  50%  25%  <25%  
 not at all

**Optional Questions:** *to get to know your interests and expectations*

Please let us know your general feelings about vaccinations for your pet and infectious disease risks:

Are you aware of or interested in the option and uses of titer testing for some of the common infectious diseases in pets, to decide whether vaccination is necessary?

What are your views and thoughts on Complementary and Alternative Veterinary Medicine, such as herbal therapies, food therapy, homeopathy, and acupuncture?

Any other concerns or questions regarding your pet's health and wellness?

Presenting Guardians's Name: \_\_\_\_\_