

KATY VETERINARY CLINIC

ILLNESS HISTORY FORM

Client Last Name: _____, First Name: _____

Patient Name: _____

Date: _____

What is/are your pet's primary complaint(s) today?

Check the following signs/symptoms that your pet is experiencing:

Not eating ____ How long? _____

Not drinking ____ How long? _____

Lethargic ____ Vomiting ____ Diarrhea ____

Sneezing ____ Coughing ____ Shaking head ____

Runny eyes ____ Runny nose ____ Drinking more water ____

Limping ____ Hair loss ____ Itching/scratching ____

Scotting ____ Weight loss ____ Weight gain ____

Other _____

Is your pet current (if an adult, within the past 12 months) on vaccinations? (Circle one) Yes No
If no, when are they due? _____

Is your pet urinating normally? _____

Does your pet have normal/regular bowel movements? _____

What is your pet's regular diet? _____

Has your pet's diet changed recently? _____

Is your pet on heartworm preventative? If so, which kind? _____

If your pet is on heartworm preventative, has he/she missed any? _____

Is your pet currently using a flea preventative such as Frontline or Advantage? _____

Is your pet currently taking any medications? _____
