New Patient Information

Date_____

Pet's Name: _____

Species: (please circle) Dog Cat

Breed: _____ **Color**: _____

Age or Birth date: _____

Sex: (please circle) Male Female

Spayed/Neutered: (please circle) Yes No

History

Vaccination History: (date and type of last vaccinations)

_____

_____

Current Medications:_____

Reason for visit:_____

Please check any symptoms or problems that you have noticed about your pet.

- ☐ **Bad breath**
- ☐ **Behavior Problems**
- ☐ **Bleeding Gums**
- ☐ **Breathing Problems**
- ☐ **Coughing**
- ☐ **Diarrhea**
- ☐ **Eye Redness**
- ☐ **Gagging**
- ☐ **Lack of Appetite**
- ☐ **Limping**
- ☐ **Loss of Balance**
- ☐ **Scooting**
- ☐ **Scratching**
- ☐ **Seems Depressed**
- ☐ **Shaking Head**
- ☐ **Sneezing**
- ☐ **Increased Thirst**
- ☐ **Increased Urination**
- ☐ **Vomiting**
- ☐ **Weakness**
- ☐ **Weight Problems**
- ☐ **Other**_____ _____ _____