CAPE HORN
Veterinary Associates

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Medical History: *(Please fill out carefully and completely)*

Date:______________ Client Name:____

Patient Name:________________________ Age:____________ Sex: Male/Female Spay/Neuter

Species:___________ Breed:_____________________________Color:__________________________

Why did you bring your pet in today? Major health problem?___________________________________
____
____
____
____

When did the problem start?___________________Is it chronic or intermittent?___________________

Has your pet had any other problems in the past?____
____

Has your pet had any x-rays or blood work within the last 6 months? Yes/No
If yes, what hospital?__________________________________Phone:__________________________

Bones, Muscles, and Ligaments:

Is your pet lame? Yes/No Where is the lameness?____

Is it chronic or intermittent?____

Does exercising make your pet better or worse?____

Does the weather affect your pet? Yes/No Cold or Hot?______________ Season:________________

Do you think your pet is in pain? If so, where?____

Has your pet had surgery or other treatment for the lameness or a back problem? Yes/No
If yes, when and where?____

Skin Appearance:

Circle all that apply: red / dry / flaky / itchy / greasy / crusty / scabby / oozing / odor / hair loss

Where is the primary location of the skin problem?____
____

Are the problems seasonal? Yes/No Is the itching worse during the day or night?_______________

Are you using any flea or heartworm control products? Yes/No If so, what?_____________________

Gastrointestinal:

How is your pet's appetite? Good / Fair / Poor / Not at all Energy Level: Good / Fair / Poor / Not at all

Gums/Teeth: Does your pet have bad breath? Yes/No Bad teeth? Yes/No Any ulcers? Yes/No

Amount of water intake: Large / Normal / Small / Not Drinking

Is your pet vomiting? Yes/No If so, what? Bile / Fluid / Undigested Food / Grass / Foreign Bodies
When does your pet vomit? Describe:____
How often?____

Does your pet have any gurgling sounds coming from the abdominal region? Yes/No

Stools: Normal / Diarrhea / Undigested Food / Mucus / Blood / Hard / Soft / Strong Odor / Constipated

Does your pet pant a lot? Yes/No

Urine: Any changes? Color / Odor / Frequency / Straining
Describe:____

Is your pet incontinent? Yes/No Any medications?____

Has your pet ever had Kidney Stones / Bladder Stones / Crystals / Bladder Infections?
If so, when?____

Heart and Lungs:

Does your pet cough? Yes/No Is it: More at Night / During Exercise / Seasonal?

Type of cough: Hacking / Wheezing / Dry / Moist / Gagging / Frequent / Infrequent / Chronic / Weak

Any history of a heart murmur? Yes/No Since when?____

Any unusual behavior? Anxiety / Pacing / Howling / Fearful / Confusion

Other problems, please describe:____

Neurologic:

Seizure Activity: When did the seizures start?_______________________________________

How long do they last?______________________ How often do they occur?______________________

Does you pet lose control of his/her bladder? Yes/No

Is your pet on any medications for the seizures? Yes/No If so, what?____________________________

Eyes:

Eye Problems? Yes/No If yes, which eye? Right / Left / Both

Discharge? Yes/No If yes, what color is it? Clear / Green / Yellow / White / Gray

Are the eyes red or dry? Yes/ No

Are you using any medications? Yes/No What medications?__________________________________

Ears:

Ear Problems? Yes/No If yes, which ear? Right / Left / Both

Problems: Shaking Head / Odor / Discharge / Chronic / Acute

Nose:

Any discharge? Yes/No If yes, for how long?___________________ One or Both Nostrils?__________

What color is the discharge?____________________ Is there Blood / Mucus / Scabbing / Crusting?

Daily Diet and Medications (please be very specific listing brand and ingredients):

Dry Food:____

Canned Food:____

Raw Food:____

Home-Cooked Food:____

Snacks/Treats:____

How many times a day do you feed your pet?____

Is your pet on any supplements? Yes/No If so, what kind and how often?
Vitamins:____

Herbals/Nutraceuticals:____

Essential Fatty Acids:____

Arthritis Medications? Glucosamine / MSM / Glycoflex / Joint Response / Rimadyl / Yucca / Ectogesic / Prednisone / Aspirin / Others? Please describe dose and strength:_______________________________
____

Is you pet on any other medications? Yes/No If so, please list the name of the medication, the dosage, how many doses per day, and how long the pet has been on the medication:____
____
____

Does your pet have any known allergies to food, drugs, or products? Yes/No If so, please list the allergies: ____

When was your pet last vaccinted?____

How often does your pet get exercise? Everyday / Often / Not so Often / None

Does your pet spend more time indoors or outdoors?____

Where did you get your pet?_______________________________________ When?____________

We kindly ask that you call your previous veterinary clinic/hospital and have the most recent labwork, x-rays, and medical records from at least the past 2 years faxed to 717-417-5566 or emailed to CapeHornVet@gmail.com.