CAPE HORN
Veterinary Associates
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MEDICAL HISTORY: (*Please fill out carefully and completely*) Date: _____

Client Name: _____ Client Phone: _____

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 preventatives? 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 heart/lung problems, please describe: _____

_____

NEUROLOGIC:

Seizure Activity: When did the seizures start? _____

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

Does your 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 If so, what? _____

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 your pet on any other medications? Yes / No
If so, please list name of medication, 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 and reactions: _____
_____

When was your pet last vaccinated? _____

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 Reception@CapeHornVet.com.