



Pet's Name \_\_\_\_\_

Owner's Name \_\_\_\_\_ Date \_\_\_\_\_

Please give us the following important information about your pet: Age \_\_\_\_\_ Weight \_\_\_\_\_  
Reviewed by: \_\_\_\_\_

Briefly describe your pet's problem/reason for visit: \_\_\_\_\_  
\_\_\_\_\_

1.) My pet has had this illness or injury for \_\_\_\_\_  
(Please circle one)  
Hours      Days      Weeks      Months      Years

2.) Habitat:  
 Indoor only       Mostly indoor       Outdoor only  
 Mostly outdoor       In and out freely

3.) Water Consumption:  
 Drinks excessively       Not Drinking       Same as usual  
 Drinking less       Drinking more

4.) Foods:  
Pet Normally Eats: \_\_\_\_\_  
 Eats specific meals       Fed free choice \_\_\_\_\_  
%Table Food \_\_\_\_\_ % Treats \_\_\_\_\_ % other \_\_\_\_\_

5. Appetite:  
 Very Good       Good       Erratic  
 Picky       Poor       Very Poor  
Change in appetite       Up       Down

6.) Activity Level:  
 Very Active       Normal       Very Inactive  
Change in activity level:  
 More Active       Less Active

7.) Behavior: Any notable change? (Describe) \_\_\_\_\_  
\_\_\_\_\_

8.) Lameness: Which leg(s) \_\_\_\_\_  
 Constant       Intermittent      Duration \_\_\_\_\_  
Difficulty Rising:  No       Yes      Duration \_\_\_\_\_

9.) Reluctance to Jump or Run:  No       Yes      Duration \_\_\_\_\_

10.) Vomiting:  
 None/Uncommon       Occasionally       Frequent  
Frequency \_\_\_\_\_  
What is vomited? \_\_\_\_\_  
Is there a constant relationship to eating? \_\_\_\_\_

11.) Diarrhea:  
 None/uncommon       Occasionally       Frequent  
Frequency \_\_\_\_\_  
Number of bowel movements per day: \_\_\_\_\_  
Straining to defecate:       Yes       No

12.) Coughing:  None       Occasionally       Frequent

13.) Sneezing:  None       Occasionally       Frequent

14.) Nasal Discharge:  
 No       Yes       Pus  
 Watery       Bloody       Duration \_\_\_\_\_

Itching:  
 None       Seasonal       Year-Round  
Locations: \_\_\_\_\_

16.) Eye Discharge: Which eye(s) \_\_\_\_\_  
 Constant       Intermittent       Duration \_\_\_\_\_  
 Pus       Watery

17.) Ears: Head-shaking, scratching, odor from -  
Which ear(s)? \_\_\_\_\_ Duration \_\_\_\_\_

18.) History of Fight Wounds:  No       Yes  
How many in last 2 years? \_\_\_\_\_

19.) Lumps/Bumps/Masses: Duration \_\_\_\_\_  
PLEASE ASK FOR A SKIN MARKER TO IDENTIFY THESE AREAS.

20.) Ticks Noted Recently:  Yes       No

21.) Fleas Noted Recently:  Yes       No

22.) On Heartworm Preventive?  
 No       Irregularly       Regularly  
 Daily       Monthly \_\_\_\_\_ # months per year  
Name of Heartworm Preventive used:  
\_\_\_\_\_

23.) Medications Regularly Taken:  
 Heartworm Preventive  
 Monthly Flea Products (Brand \_\_\_\_\_)  
 Others: \_\_\_\_\_

24.) CATS: Has tested positive for:  
 Feline Leukemia Virus  
 Feline Immunodeficiency Virus

To determine a diagnosis and begin treatment, laboratory tests or radiology services may be required. The Doctor will call you at the number you provide below to discuss these procedures and cost. Vaccinations are required if your pet is well enough to receive them. If your pet is due vaccinations, your pet will be vaccinated before treatment or surgery. All pets must be free of both internal and external parasites.

When did your pet last eat? \_\_\_\_\_

What medications have you given in the last 24 hours (note time given also)? \_\_\_\_\_

If it becomes necessary to send home medication with my Pet, I prefer:  Liquid       Tablets

I AUTHORIZE BCAH TO EXPEND UP TO \$ \_\_\_\_\_  
IN DIAGNOSIS OR TREATMENT OF MY PET AS NEEDED.

Please call if additional services are required. In the event of a life-threatening condition, we will make every attempt to stabilize your pet and notify you as soon as possible. If that is not possible, we will treat the animal at the owner's expense.

Signature \_\_\_\_\_  
(Owner/Agent)

I can be reached at the following phone number:  
\_\_\_\_\_