# TTVC PET HISTORY FORM

Date: ______________
Pet's Name: _________________________________
Last Name: __________________________________

Is your pet current on all vaccinations? ( ) Yes ( ) No

Which clinic did they receive their vaccinations at?
__________________________________________

Is your pet spayed or neutered? ( )Yes ( ) No

Is your pet on heartworm prevention?
Type: ( )Heartgard ( )Revolution
Other: __________________________________

What type of flea control do you use on your pet?
( ) Frontline ( ) Nexgard ( )Revolution
Other: __________________________________

Has your pet been passing worms? ( ) Yes ( ) No
Describe:_________________________________

Any injury or illness in the past 30 days? ( )Yes ( ) No
Describe:__________________________________

Does your pet have a history of having seizures?
( ) Yes ( ) No

Is your pet currently on any medications ? ( )Yes ( )No
If so, List medication name and dosage:
_____________________________________________
_____________________________________________

Is your pet allergic to any medications/ drugs ?
( ) Yes ( ) No If so, what kind?
_____________________________________________

What food is your pet currently eating?
_____________________________________________

Are there any food intolerances/ allergies ? ( ) Yes ( )No
If so, what? ___________________________________

Has your pet hand any of the following symptoms in the past 30 days ?
Vomiting? ( )Yes ( ) No Diarrhea? ( ) Yes ( ) No
Sneezing? ( ) Yes ( ) No Coughing? ( ) Yes ( ) No
Gagging? ( ) Yes ( ) No Lethargic? ( ) Yes ( ) No
Shaking head?( ) Yes ( ) No Scratching? ( ) Yes ( ) No

Any hair loss? ( ) Yes ( ) No If yes:
( )Patchy ( )Generalized ( ) Excessive Shedding

Is your pet scooting? ( ) Yes ( ) No

In the past 30 days, how is your pet's appetite?
( ) Normal ( ) Increased ( ) Decreased

In the past 30 days, have you noticed any of the following with your pet's weight?
( ) Stable ( ) Losing ( ) Gaining

Have you noticed a change in water consumption?
( ) Normal ( ) Increased ( ) Decreased

Have your pet's bowel movements been:
( ) Normal ? ( ) Diarrhea? ( ) Constipated?

Is your pet's urination:
( ) Normal? ( ) Increased Frequency? ( ) Increased Amount?
Is your pet straining to urinate? ( ) Yes ( ) No

Does your pet have any lumps or bumps?( ) Yes ( ) No
Location of lumps:
_____________________________________________

Does your pet have bad breath? ( ) Yes ( ) No

Has your pet had a dental ? ( ) Yes ( ) No
If yes, when was the last dental ?
_____________________________________________

Have you noticed any of the following in your pet? :
Lameness or Stiffness? ( ) Yes ( ) No
Which leg? _______________________
Difficulty rising after sitting? ( ) Yes ( ) No
Difficulty rising after sleeping? ( ) Yes ( ) No
Difficulty rising after exercise? ( ) Yes ( ) No

Have you noticed any behavioral changes in the last 30 days? ( ) Yes ( ) No

Describe :
_____________________________________________
_____________________________________________

Do you have any other concerns?
_____________________________________________
_____________________________________________