Northeast Veterinary Referral Hospital
Internal Medicine
NEW PATIENT HISTORY SHEET

Client Name_____ _____Patient Name:_____

Date:_____

Date of Birth:_____ _____Sex: Male Female Male Neutered Female Spayed

Species: Feline Canine Breed: _____

What is your pet's current problem: _____

_____

_____

Do you have any other pets at home? (If yes, what are they?) _____

_____

What do you currently feed your pet? _____

When was your pet last vaccinated? _____

Are you using any flea/tick/heartworm preventive? (please list)_____

Cats:

Has your cat been tested for feline leukemia and/or FIV? (if yes, when and results:)_____

_____

Does your cat stay (please circle): Indoors only Outdoor only Indoor & Outdoor

Dogs:

Has your dog been tested for heartworm and/or lyme disease? (if yes, when and results:)

_____

All Patients:

Please list any previous health problems, surgeries or allergies we should know about:

_____

_____

Please list current medications (including over-the-counter), when started, dosage and response:_____

_____

_____

_____

_____

See other side -->

Has your pet exhibited any of the following? (Please circle all that apply)

Lethargy:	Yes	No
Drinking a lot of water:	Yes	No
Frequent or difficult urination	Yes	No
Urinating frequently:	Yes	No
Changes in appetite:	Yes	No
Vomiting:	Yes	No
Diarrhea:	Yes	No
If yes, please description:	Bloody	Clear	Mucous	Black stool
Constipation, straining:	Yes	No
Recent weight loss:	Yes	No
Coughing:	Yes	No
Sneezing:	Yes	No
Panting/Gasping for breath:	Yes	No
Gagging / retching :	Yes	No

For each "Yes" circled above, please describe and not frequency, duration, progression, response to treatment, and/or any other information:

_____

_____

_____

_____

Does your pet have any other problems we should know about?

_____

_____

Staff use only:

Time:_____ Initials: _____

T _____ P _____ R _____

wt _____ CRT _____ mm _____