PATIENT INFORMATION AND HISTORY

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BREED: \_\_\_\_\_\_\_\_\_\_\_AGE:\_\_\_\_\_\_GENDER:\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIET:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPPLEMENTS/HERBS:

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| History (circle all that apply and add details as needed) When did symptoms start? \_\_\_\_\_\_\_\_\_\_How long have they been going on?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When do symptoms occur? Season\_\_\_\_\_\_\_\_\_\_\_\_Hour\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Energy level: Better in morning/evening/can’t tell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Temperature preference: shade or tile/sunny or carpet/no preference\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Thirst: normal/increased/decreased/frequent small sips\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Appetite: normal/increased/ravenous/decreased/finicky\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Vomiting: none/food/fluid/noisy/silent/frequent/sporadic/morning/evening/how long after eating\_\_\_\_  Stool: Normal/diarrhea/constipation/mucous/blood/incontinence/gas/smelly/color\_\_\_\_\_\_frequency\_\_\_  Urine: normal/increased/decreased/pale/yellow/dark/bloody/smelly/incontinence/retention/pain\_\_\_\_\_  Behavior: relaxed/happy/hyperactive/outgoing/confident/quiet/timid/angry/fearful/sad/worried/  caring/loyal/ friendly/aggressive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pain/stiffness: none/worse with rest/exercise/hot/cold/damp/morning/evening/better in the morning/how long has it been going on?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sleep: normal/increased/decreased/restless/vocalizes/dreams/location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cough: dry/wet/loud/soft/productive-foam/phlegm/daytime/nighttime, worse at night\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diet: Dry kibble/canned/homemade/raw/cooked\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Respiration: normal/heavy/strong/weak/shallow/out of breath on walks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Exercise: normal/lots/too little/intolerant – quits or refuses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Massage: likes/dislikes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergies: food?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_itching?\_\_\_location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| GENERAL MEDICAL ISSUES (circle all that apply) 1.       Separation anxiety, heart problems, insomnia, thunderstorm phobia, restlessness, tachycardia, fever, pants a lot  2.       Problems with liver, ligaments, eyes, ears, nails, footpads, anal glands, aggression, seizures  3.       Loss of appetite, constipation, diarrhea, vomiting, overweight, gum disease, weak muscles, anxiety  4.       Urinary issues, back pain, bone or growth issues, weak in rear end, fearful, deaf, reproductive problems, arthritis, teeth problems, ear problems  5.       Asthma, sinusitis, coughing, breathing problems, nose problems, dry skin, sneezing, nasal discharge, weak voice |

## OTHER PERTINENT SYMPTOMS, SIGNS OR TENDENCIES:

Please use this space to describe, in as much detail as you like, the concerns you have with your pet’s health.

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