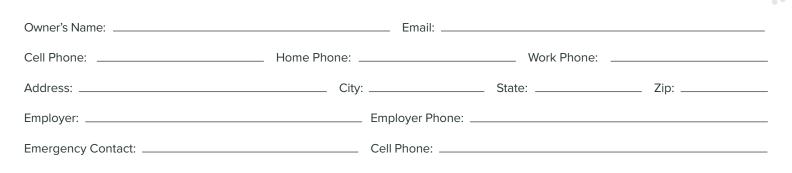


Pet's Name: \_\_\_\_







## **Pet Health History**

Please fill out the infomation below and email us your pet's medical and vaccination records from any previous veterinary care providers.

Sex: ☐ Male ☐ Female Neutered/Spayed: ☐ Yes ☐ No Microchipped: ☐ Yes ☐ No Microchip #: \_\_\_\_\_\_

Canine/Feline/Avian/Other: \_\_\_\_\_\_ Breed: \_\_\_\_\_

\_\_\_\_\_ Pet Birthdate: \_\_\_\_\_

\_\_\_\_\_ Color: \_\_\_\_\_

Current Medications:			
Prior Surgeries:			
Prior Illnesses:			
Primary Reason for Visit:			
Symptoms your pet is demonstratin	g:		
☐ Apetite Loss	☐ Diarrhea	☐ Loss of Balance	☐ Thirst
☐ Behavioral Changes	☐ Eye Disorders	☐ Scooting	☐ Urination Increase
☐ Breathing Problems	☐ Gagging	☐ Scratching	☐ Vomiting
☐ Coughing	☐ Gums Bleading	☐ Shaking Head	☐ Weakness
☐ Depression	☐ Limping	☐ Sneezing	☐ Other:
	Most Current Vaccin	ations and Heartworm '	Test
Distemper Date: Parvovirus Date:		Rabies Date:	Heartworm Date:

## **Authorization**

□ I hereby authorize the veterinarian to examine, prescribe for, or treat the above pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that all professional fees are due at the time services are rendered.

Accepted forms of payment include all major credit cards and Scratch Pay. We do not accept Care Credit.

Signature of Responsible Party: \_\_\_\_\_\_ Date: \_\_\_\_\_