

Integrative Veterinary Center

5525 Elvas Avenue Sacramento, CA
PHONE (916)454-1825 Fax (916) 454-5865

Medical History: Please fill out carefully and completely

Date: _____ Client Name: _____

Patient Name: _____ Age: _____ Sex: Male/Female Spay/Neuter

Species: _____ Breed: _____ Color: _____

Why did you bring your Pet in today, Major Health Problem? _____

When did the problem start? _____ Is it Chronic or Intermittent? _____

Has your Pet had another other problems in the past? _____

Has your pet had any x-rays or blood work within the last 6 months? Yes/No

If, Yes what Hospital: _____ Phone: _____

Bones, Muscles, and Ligaments:

Is your Pet Lame? YES/NO Where is the lameness? _____

Is it Chronic or Intermittent? _____

Does exercising make your Pet better or worse? _____

Does the weather affect your Pet? YES/NO Cold or Hot? _____ Season: _____

Do you think your Pet is painful? If so, where? _____

Has your Pet had surgery or other treatment for the lameness or a back problem? YES/NO

If yes, when and where? _____

Skin Appearance:

Circle all that apply: red / dry / flaky / itchy / greasy / crusty / scabby / oozing / odor / hair loss

Where is the primary location of the skin problem? _____

Are the problems Seasonal? YES/NO Is the itching worse during the DAY or NIGHT?

Are you using any flea or heartworm control products? YES/NO If so, what? _____

Gastrointestinal:

How is the appetite? Good / Fair / Poor / Not at all Energy Level: Good / Fair / Poor / Not at all

Gums/ teeth: Does your pet have bad breath? YES/NO Bad teeth? YES/NO Any ulcers? YES/NO

Amount of water intake: Large / Normal / Small / Not Drinking

Is your Pet vomiting? YES/NO If so, what? Bile / Fluid / Undigested Food / Grass / Foreign Bodies

When does your pet vomit? Describe: _____

How often? _____

Does your Pet have any gurgling sounds coming from abdominal region? YES/NO

Stools: Normal / Diarrhea / Undigested Food / Mucus / Blood / Hard / Soft / Strong Odor / Constipated

Does your Pet pant a lot? YES/NO

Urine: any changes in Color / Odor / Frequency / Straining

Describe: _____

Is your Pet incontinent? YES/NO Any medications? _____

Has your Pet ever had Kidney Stones / Bladder Stones / Crystals / Bladder Infections?

If so, when? _____

Heart and Lungs:

Does your Pet cough? YES/NO Is it: More at Night / During Exercise / Seasonal?

Is the cough: Hacking / Wheezing / Dry / Moist / Gagging / Frequent / Infrequent / Chronic / Weak

Any history of a heart murmur? YES/NO Since when? _____

Any unusual behavior? Anxiety / Pacing / Howling / Fearful / Confusion

Other problems please describe: _____

Neurologic:

Seizure Activity: When did the seizures start? _____

How long do they last? _____ How often do they happen? _____

Does you Pet lose control of his/her bladder? YES/NO

Is your Pet on any medications for the seizures? YES/NO If so, what? _____

Eyes:

Eye Problems? YES/NO Which Eye: Right / Left / Both

Discharge? YES/NO Is it Clear / Green / Yellow / White / Gray Are the eyes Red or Dry? YES/ NO

Are you using any medications? YES/NO What medications? _____

Ears:

Ear Problems? YES/NO Which Ear: Right / Left / Both

Problems: Shaking Head / Odor / Discharge / Chronic / Acute

Nose:

Any Discharge? YES/NO If so, for how long? _____ One or Both Nostrils? _____

What color is the discharge? _____ Is there Blood / Mucus / Scabbing / Crusting

Daily Diet and Medications (please be very specific listing brand and ingredients):

Dry Food: _____

Canned Food: _____

Raw Food: _____

Home Cooked Food: _____

Snacks/Treats: _____

How many times a day do you feed your Pet? _____

Is your Pet on any supplements? YES/NO If so, what kind and how often are you giving:

Vitamins: _____

Herbals/Nutraceuticals: _____

Essential Fatty Acids: _____

Arthritis Medications? Glucosamine / MSM / Glycoflex / Joint Response / Rimadyl / Yucca / Ectogesic / Prednisone / Aspirin / Others? Please describe dose and strength: _____

Is you Pet on any other medications? YES/NO If so, what is the medication, the dosage, and how many times per day? _____

How long has your Pet been on these medications? _____

Does your Pet have any known ALLERGIES from Food, Drugs, or Products? YES/NO If so, what is your pet allergic to? _____

When was your pet last vaccinted? _____

How often does your pet get exercise? Everyday / Often / Not so Often / None

Does your Pet spend more time Indoors or Outdoors? _____

Where did you get your Pet? _____ When? _____

If you did not bring any records today or have them emailed or faxed to our office prior to your visit by your previous Veterinarian we kindly ask if you can please call your previous Veterinary Hospital and have the most recent labwork, x-rays, and medical records from at least the past 2 years faxed to (916)454-5865 or emailed to integrativevet@att.net! Thank you very much!

