Union Pet Hospital

Canine/Feline

Your Pet's Medical Information and History

Your Name:_____ Pet's Name:_____ Date:_____

Instructions: Please circle YES or NO

Reason for today's visit? _____

Has your address or phone number changed since your last visit? **YES NO**

If yes, please specify any changes:_____

What is your email address? _____

Have you been to The Erlanger Veterinary Hospital or Pet Resort recently? **YES NO**

Are you interested in pet insurance? **NO YES**

Does your pet travel out of state? If so, where? **NO YES** _____

Do you board or groom your pet? **NO YES**

Do you brush your pet's teeth? **NO YES**

What is your pet's diet (Brand)? _____

Has your pet shown any of the following **signs** or **symptoms**? If yes, please **circle the symptoms:**

UNUSUAL BODY ODORS		BAD BREATH		SHAKING HEAD/EARS	
COUGHING	SNEEZING	WHEEZING	GAGGING	CHOKING	
ITCHING	HAIR LOSS	SKIN PROBLEMS		POOR HAIR/ COAT	
VOMITING	DIARRHEA	SCOOTING REAR END		LUMPS	BUMPS
LIMPING	LAMENESS	STIFFNESS	LISTLESS	WEAKNESS	SEIZURES
UNUSUAL DISCHARGE		SQUINTING	EXCESSIVE PANTING		TREMORS

Has your per **shown significant changes** in any of the following?

Character of bowel movements?	**YES**	**NO**	Appetite?	**YES**	**NO**
Frequency or amount of urination?	**YES**	**NO**	Drinking?	**YES**	**NO**
Weight gain or loss?	**YES**	**NO**	Behavior?	**YES**	**NO**