FISCHER VETERINARY CLINIC: NEW CLIENT INFORMATION

HOW DID YOU HEAR ABOUT US?	DATE:

OWNER INFORMATION

First name:		Last name:	
Address:		City:	Zip:
Home phone:	Cell:	Email:	

PATIENT INFORMATION

Pet's name:	Pet's date of birth:	☐ Male ☐ Female ☐Spayed/neutered
Species: ☐ Dog ☐ Cat ☐ Other	Breed:	Color:

HISTORY

Which food does your pet eat?☐Canned☐Dry☐Other	How much?	How often?
What kind of treats/ snacks/ table scraps/ chews do you give your pet?		
Does your pet have a microchip? Y N	Your pet lives: Inside___% Outside___%	
Is your pet on heartworm prevention? Y N	Brand:	
Has your pet ever had heartworms? Y N	Date last HW prevention given:	
Cats ONLY: Has your cat ever been tested for Feline Leukemia/FIV? Y N	Date tested:	Result: + -
Has your pet ever had an ECG to check heart status? Y N		
Please list all pet's surgeries other than spay/neuter:		
Current medications/supplements:		
Vaccination status: ☐ Current ☐ Needed		
Do you have any other pets in the house? ☐Dogs How many? ☐Cats How many?		

PRIMARY REASON FOR TODAY'S VISIT

☐Wellness check	Are your pet's records available? ☐Yes ☐No
☐Medical problem	Describe problem:

BEHAVIOR

Appetite:	☐Normal	☐Decreased	☐Increased	Comments:
Water intake:	☐Normal	☐Decreased	☐Increased	Comments:
Urination:	☐Normal	☐Decreased	☐Increased	Comments:
Mobility:	☐Normal	☐Decreased	☐Increased	Comments:
Activity level:	☐Normal	☐Decreased	☐Increased	Comments:
Weakness:	☐No	☐Yes	In what way?	
Any pain? Y N	If so what level: ☺ 1 2 3 4 5 6 7 8 9 10 ☹			Location of pain:

INTERNAL

Coughing:	☐Yes	☐No	Frequency:
Sneezing:	☐Yes	☐No	Frequency:
Vomiting:	☐Yes	☐No	Frequency:
Diarrhea:	☐Yes	☐No	Frequency:

EXTERNAL

Eyes:	☐No problem	☐Vision loss	☐Cloudy	☐Red	☐Drainage	☐Rubbing	
	Other:		How long?:				
Ears:	☐No problem	☐Head shaking	☐Scratching		☐Odor	☐Seems painful	
	Other:		How long?:				
Teeth:	☐No problem	☐Bad breath	☐Trouble Eating		☐Tartar	☐ Loose/missing teeth	
	Other:		How long?:				
Skin:	☐No problem	☐Scratching	☐Rash	☐Feet chewing	☐Hair loss	☐Sores/scabs	☐Odor
	Other:		How long?:		Year round? Y N		

WHAT ELSE WOULD YOU LIKE TO TALK TO THE DR ABOUT TODAY?