

Pet Medical History

Please complete the following form to the best of your knowledge.

Client Name _____

	Pet #1	Pet #2	Pet #3
Pets Name			
Species (cat, dog, goat etc.)			
Breed			
Description (color)			
Date of Birth or Age			
Sex - Please Circle One	Male Female	Male Female	Male Female
Has He/She Been Neutered/Spayed?	Yes No	Yes No	Yes No
Approximate Date of Last Vaccinations			
Name of Clinic / Doctor where Previously Seen			
Length of time owned			
Flea Meds (Advantage, etc.)			
Any Medications / Vitamins			
Any Known Allergies (Food, Fleas, Antibiotics, etc)			
Diet (kind of pet food) i.e. Dry, Canned, Prescription			
Hours Outside per Day			
Pet Origin (breeder, stray, etc)			
Microchip Number			
King County License Number			
Dog - Heartworm Test Date			
Cat - FeLV/FIV Test Date			
Goat - CAE Test Date			