

# Crystal Mountain Animal Hospital

## Client/ Patient Information Sheet

Your Name \_\_\_\_\_

Spouse Name \_\_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Pet's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Breed \_\_\_\_\_ Species (Dog/Cat) \_\_\_\_\_

Color and Markings \_\_\_\_\_

Neutered (Male) Spayed (Female)

Microchip/ Tattoo# \_\_\_\_\_

How did you hear about us?

Personal Referral: name: \_\_\_\_\_

Referral: Name \_\_\_\_\_

Yellow Pages Ad (What book?) \_\_\_\_\_

Internet (what source): \_\_\_\_\_

Website: \_\_\_\_\_

Full payment is required at the time services are provided. I understand that the hospital staff will provide an estimate of current and anticipated charges anytime I request one. By signing below, I am requesting that veterinary care be provided for pets presented by me and agents. I understand that I am financially responsible for all services provided.

\_\_\_\_\_  
Signature Date

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## Comprehensive Pet History

- Is your address & phone # correct: \_\_\_\_\_
- If first visit, is this your first pet: \_\_\_\_\_
- Are you aware of pet insurance: \_\_\_\_\_
- Chief Complaint or Reason for Visit: \_\_\_\_\_
- Last Vaccination Date for a dog: DA2PP: \_\_\_\_\_, Parvo: \_\_\_\_\_, Rabies: \_\_\_\_\_, Bordetella: \_\_\_\_\_
- Last Vaccination Date for a cat: RCPN: \_\_\_\_\_, Leukemia: \_\_\_\_\_, Rabies: \_\_\_\_\_
- Has your pet been tested for intestinal parasites within the past 6 months: \_\_\_\_\_
- Have you seen your pet passing any worms: \_\_\_\_\_
- Has your pet had a heartworm test: \_\_\_\_\_
- Is your pet spayed/neutered: \_\_\_\_\_
- Any injury or illness in the past 30 days: \_\_\_\_\_
- Does the pet have a history of having seizure: \_\_\_\_\_
- Is your pet currently on any medication: \_\_\_\_\_
- Is your pet allergic to any drugs/medications: \_\_\_\_\_
- Diet/Brand of Food: \_\_\_\_\_ How many times a day do you feed your pet and how much: \_\_\_\_\_
- Pet Treats: \_\_\_\_\_
- Does your pet get table scraps: \_\_\_\_\_
- Are there any food intolerances: \_\_\_\_\_
- Did your pet eat this morning: \_\_\_\_\_

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- Appetite: \_\_\_\_\_Increased \_\_\_\_\_Normal \_\_\_\_\_Decreased
- Weight: \_\_\_\_\_Loss \_\_\_\_\_Gain \_\_\_\_\_Stable
- Water Consumption: \_\_\_\_\_Increased \_\_\_\_\_Normal \_\_\_\_\_Decrease
- Bowel Movement: \_\_\_\_\_Constipated \_\_\_\_\_Normal \_\_\_\_\_Diarrhea (how long)
- Urination: \_\_\_\_\_Increased \_\_\_\_\_Normal \_\_\_\_\_Increased Amount \_\_\_\_\_Increased Frequency
- Straining to Urinate: \_\_\_\_\_
- Vomiting: \_\_\_\_\_
- Coughing: \_\_\_\_\_
- Sneezing: \_\_\_\_\_
- Gagging: \_\_\_\_\_
- Any Listlessness: \_\_\_\_\_
- Any Weakness: \_\_\_\_\_
- Shaking Head: \_\_\_\_\_
- Scratching: \_\_\_\_\_
- Significant Hair Loss: (patchy, excessive shedding, or generalized) \_\_\_\_\_
- What Flea Control do you use: \_\_\_\_\_
- Scooting: \_\_\_\_\_
- Unusual lumps or bumps: \_\_\_\_\_
- Bad Breath: \_\_\_\_\_
- Unusual Discharge: \_\_\_\_\_
- Lameness: (which leg) Please indicate: \_\_\_\_\_

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- Difficulty Rising: \_\_\_\_\_
  - After sleeping, after exercise: \_\_\_\_\_
- Stiffness: \_\_\_\_\_
- Any behavioral changes (please describe): \_\_\_\_\_
- Do you wish to be present while your pet is examined: \_\_\_\_\_

Anything else we need to know?