CRVS
Columbia River VetERinary Specialists
*Specialized **Care** when it **matters most.***

PLACE CLIENT/PET LABEL HERE

Pet's name: _____

Owner's last name: _____

SURGERY DEPARTMENT
PATIENT HISTORY

Date: _____ Time:_____

Briefly describe problem/complaint: _____

Goals of today's visit: _____

Please check yes or no to the following questions (use bottom of page to elaborate, if needed)			
		YES	**NO**
1.)	Is your pet current on all vaccines?		
2.)	Are there other pets in your household?		
3.)	Is your pet CURRENTLY receiving medication for flea/tick/heartworm prevention?		
4.)	Has your pet ever had a seizure?		
5.)	Has your pet ever had a reaction/side effects from a medication?		
6.)	Has your pet had any vomiting?		
7.)	Has your pet had any diarrhea OR loose stools?		
8.)	Has your pet had any coughing or sneezing?		

Please circle the WORD that BEST describes your pet's RECENT ACTIVITY

- Is your pet **INDOOR/ OUTDOOR / BOTH**?
- Has there been an **INCREASE / DECREASE / NO CHANGE** in your pets *energy level*?
- Has there been an **INCREASE / DECREASE / NO CHANGE** in your pets *appetite*?
- Has there been an **INCREASE / DECREASE / NO CHANGE** in your pets *water intake*?
- Has there been an **INCREASE / DECREASE / NO CHANGE** in your pets *urination*?

CURRENT MEDICATIONS				
	NAME of MEDICATION	DOSE	HOW OFTEN?	When was it last given?
1.)				
2.)				
3.)				
4.)				

How long have you had your pet? _____

What diet is your pet currently eating (Brand, dry/canned)? _____

How much and how often? _____

Any table scraps or treats? _____

How much and how often? _____

PLEASE TURN OVER AND CONTINUE ON THE BACK

Surgery
PATIENT HISTORY

Please list any previous medical or surgical problems: _____

_____

Is there any additional information that you would like us to know, or is there any specific questions you may have?

_____

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