CRVS
Columbia River VetERinary Specialists
We Care.

Patient History

Pet's Name: ______________________________ Owner's Name: ____________________________________
Date: ___________________________________ Time:____

Problem/complaint:____
When did this problem start?____

Has your pet been treated for any medical or surgical problems previous to this visit? ____________________
If yes, describe____
How long have you owned your pet?____
Other pets in the household?____

Is your pet: female / male? spayed or neutered?
If not spayed when was her last heat?___________ Is she pregnant? yes / no

When was your pet last vaccinated against viral diseases? __________________ Rabies?__________________
Cats only: Has your cat been tested for FELV/FIV? yes / no Results? __________________________________

Is your pet currently receiving medications to prevent heartworm/fleas/ticks?
Please list type of medication used ____

Is your pet indoor/outdoor/both___________ If outdoors are they supervised?_______________
Do they have neighborhood access? yes / no

Has your pet had access to raw fish? yes/ no Access to garbage? yes / no

What kind of food does your pet normally eat?____
Access to table scraps or meat bones? yes / no If yes please specify__________________________________

Has your pet traveled outside of the Pacific Northwest? ____
When/where?____

Is your pet currently taking any medications? (please include any pain medications, vitamins/supplements)
____
____

Has your pet ever had a reaction to or side effects from a medication? ________________________________
____

Has your pet ever had a seizure? yes / no

Please turn over and complete page 2

The following questions are based on the last 24-48 hours

Has there been any change to your pet's energy level or behavior recently? yes/no
If yes, please describe____
____

Has there been an increase or decrease in your pet's appetite recently? (circle one if applicable)

Has there been an increase or decrease in your pet's water intake recently? (circle one if applicable)

Has your pet had any access to toxins: yes / no When?__________________________________
Type/amount____

Has your pet had any vomiting? yes / no
When did it start?____
How often, how much? ____

Has your pet defecated? yes / no When was the last normal stool?______________
Any diarrhea? yes / no Any straining? yes / no Any blood? yes / no

Does your pet have a history of urinary problems? yes / no
Is your pet urinating more frequently than normal? yes / no
Any straining to urinate? yes / no
Any blood in the urine or discoloration? yes / no

Is your pet coughing? yes / no When did it start?____
Describe____

Is your pet sneezing? yes / no When did it start?____________________________________
Is there any nasal discharge or bleeding? ____