In order to expedite your visit, please provide us with the following information to the best of your ability. If you are unsure of a question, please notify the attending technician.

- Reason for visit: ____________________________________________________________
- How long have the symptoms been present? __________________ Are they new or recurrent? (circle)
- Are the symptoms the same, worse or improving since first observed? __________
- How long have you owned your pet? __________
- Please list any places lived or visited outside the San Antonio area: ______________________________

General (Please circle appropriate response)
Pet Location: Indoors Free Roaming Fenced Outdoors
Appetite: Normal Increased Decreased
Water consumption: Normal Increased Decreased
Weight: Normal Increased Decreased (how much_______)
Activity Level: Normal Increased Decreased

Gastrointestinal
Vomiting: No Yes Frequency: _______________
Defecation: Normal Constipation/Diarrhea Dripping/Leaking stool

Urinary
Drinking more than normal? No Yes Duration: ___________________________
Straining to urinate? No Yes
Urination frequency/amount: Normal Increased Dripping/Leaking
When did your pet last urinate? ___________________
Is the urine discolored/bloody/cloudy/malodorous/etc.? _______________________________

Respiratory/Cardiovascular
Difficulty breathing/coughing No Yes ___________________

Neurologic
Attitude/Mentation: Normal/Alert Depressed Disoriented Strange Behavior(s)
Collapse: No Yes Frequency: ___________________________
Seizures: No Yes Frequency: ___________________________
Last/most recent seizure: ___________________ Age at first seizure: ___________________
Pain: None Yes Where? ___________________________
Trouble walking/lameness No Yes Where? ___________________________
Previous/Inciting Trauma: No Yes When? ___________________________
Does one side seem worse than the other? _______________________________________________
Did the problem improve with medication? No Yes Which ones? ___________________________
How long has your pet been completely unable to use their legs? ___________________________
Changes in vision/hearing: No Yes Explain: ___________________________
List any previous or ongoing illnesses in your pet’s medical history:
_________________________________________________________
_________________________________________________________

List any and all medications your pet has received in the last 6 months. Please circle and provide the dose and frequency for current medications. Please provide the date the medication was started.
_________________________________________________________
_________________________________________________________
_________________________________________________________

List additional information you have regarding today’s visit including adverse reactions to medications, anesthesia, etc.:
_________________________________________________________
_________________________________________________________

Heartworm/Flea/Tick preventatives used are: _______________________________________________