BluePearl Specialty & Emergency Pet Hospital – Stone Oak

Neurology

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? _____ Normal/Reduced/Increased Amount?

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: _____