New Patient Consultation History Sheet

Patient Name: ___________________________ DOB: ________________  Today’s Date: ________________

Gender (Circle One):  Male  Female  Is your pet neutered/spayed?  Yes  No

Species (Circle One):  Feline  Canine  Breed: ____________________________

If feline (Circle One):  Indoor  Outdoor  Both

What is your pet’s current problem? ____________________________________________

__________________________________________________________________________

__________________________________________________________________________

Do you have any other pets at home? If so, what are they? __________________________

__________________________________________________________________________

What do you currently feed your pet? ____________________________________________

__________________________________________________________________________

When was your pet last vaccinated? ____________________________________________

Are you using any flea/tick/heartworm preventative? (please list): ________________

Has your cat been tested for feline leukemia or FIV? If yes, when and what were the results? ________________

__________________________________________________________________________

Has your dog been tested for heartworm or lyme disease? If yes, when and what were the results? ________________

__________________________________________________________________________

Please list any previous health problems, surgeries or allergies we should know about: ________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Please list current medications (including over-the-counter), when started, dosage and pet’s response: ________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Staff use only:  T__________  P__________  R__________  wt__________  CRT__________  mm__________

PLEASE TURN OVER!
Has your pet exhibited any of the following? (Please circle all that apply)

- Lethargy: Yes  No
- Drinking an abnormal volume: Yes  No
- Frequent or difficult urination: Yes  No
- Urinating an abnormal volume: Yes  No
- Changes in appetite: Yes  No
- Vomiting: Yes  No
- Diarrhea: Yes  No

If yes, please circle all that apply:

- Constipation / Difficulty defecating: Yes  No  Blood  Clear Mucous  Straining  Black Stool
- Recent weight loss: Yes  No
- Coughing: Yes  No
- Sneezing: Yes  No
- Abnormal breathing: Yes  No
- Gagging / retching: Yes  No

For each “Yes” circled above, please describe and note frequency, duration, progression, response to treatment, and/or any other information:

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Does your pet have any other problems that we should know about?

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Thank you for bringing your pet to PVS-EC – Cardiology
807 Camp Horne Road, Pittsburgh, PA 15237
Phone: 412-366-3400 / Fax: 412-366-3489