Internal Medicine Patient Medical History

bluepearl™ specialty + emergency pet hospital
bluepearlvet.com

Today's date _____

Patient and client information

Patient number _____ **Age** _____

Pet's name _____ **Sex** _____

Client name _____ **Breed** _____

Primary veterinarian _____ **Species** _____

History of current problem

Primary problem or condition being evaluated today: _____

When did the primary problem start? _____

Overall, primary problem has: ☐ Improved ☐ Stayed the same ☐ Worsened **Please explain:** _____

Any other concerns regarding your pet's health today? ☐ Yes ☐ No **If yes, please explain:** _____

What medications or treatments is your pet receiving?

Medication name	Dose	How often? Last time?	Given Today	Refill
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Did you have any difficulty giving any of the medications listed? ☐ Yes, always a problem ☐ Sometimes a problem ☐ No problems

Please explain medication problems, if any: ☐ My schedule/not home when meds scheduled ☐ I forget ☐ Pet resists ☐ I have trouble giving pills ☐ Other: _____

What is your pet's current diet? Dry brand _____ Amount per meal _____ cups/scoops Number of meals a day _____

Canned/wet brand _____ Amount per meal _____ can/cup/ounces

Treats _____ When was your pet's last meal or treat? _____

Water available at all times? ☐ Yes ☐ No If no, please explain: _____

Pet's overall condition and symptoms? Check all that apply, and please write further description if appropriate.

Energy and attitude	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Weight and body condition	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Appetite/food intake	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Thirst/water intake	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Urination frequency	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Urination volume	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Urination appearance	☐ Normal/no change	☐ More yellow	☐ More clear	☐ More dark			
		☐ Red-Bloody	☐ Strains	☐ Appears painful	☐ Don't know		
Stool frequency	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Stool volume	☐ Normal/no change	☐ Increased	☐ Decreased	☐ Don't know			
Stool appearance	☐ Normal/no change	☐ Constipation	☐ Diarrhea	☐ Straining			
		☐ Mucus	☐ Red-Bloody	☐ Black-Tarry	☐ Don't know		
Skin/coat	☐ Normal/no change	☐ Hair loss	☐ More itchy	☐ Rash	☐ Don't know	☐ Other: _____	
Vomiting or regurgitation	☐ No	☐ Yes, please describe: _____					
Coughing	☐ No	☐ Yes, check below: _____					
	☐ Hacking	☐ Honking	☐ Moist	☐ Dry	☐ Productive	☐ Other: _____	
	Please describe any pattern (e.g., frequency, time and activities associated with cough): _____						
Sneezing	☐ No	☐ Yes, please describe (e.g., frequency, time and activities associated with sneeze): _____					
Nasal discharge	☐ No	☐ Yes, if so:	☐ Mucus	☐ Clear	☐ Bloody color/thick	☐ Left only ☐ Right only	☐ Both sides
Eye problems/discharge	☐ No	☐ Yes, if so:	☐ Left only	☐ Right only	☐ Both sides	Please describe:	
Pain	☐ None	☐ Improved	☐ Worse	Where? _____		_____	

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Patient number _____ **Client name** _____

Pet's name _____

Past medical issues and preventive care

Does your pet have any chronic medical conditions? ☐ Yes ☐ No **(If yes, please list below)**

Condition or illness	Estimated start date	Status (check one) and current treatments, if any
_____	_____	☐ Same ☐ Better ☐ Worse _____
_____	_____	☐ Same ☐ Better ☐ Worse _____
_____	_____	☐ Same ☐ Better ☐ Worse _____
_____	_____	☐ Same ☐ Better ☐ Worse _____

What vaccinations does your pet receive? _____ **When were your pet's last vaccinations?** _____

Does your pet get heartworm prevention? ☐ Yes ☐ No

If yes, what kind? ☐ Oral liquid ☐ Oral pills ☐ Liquid on skin ☐ Injection by veterinarian

How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Every other month ☐ Every six months ☐ Yearly

Does your pet get flea and tick prevention? ☐ Yes ☐ No

If yes, what kind? ☐ Oral liquid ☐ Oral pills ☐ Liquid on skin ☐ Medicated collar from pet store ☐ Medicated by veterinarian

How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Every other month ☐ Every six months ☐ Yearly

Does your pet spend time with other animals? ☐ Yes ☐ No **If yes, what animals?** _____

Best description of your pet's environment? ☐ Inside all the time ☐ Inside 75% ☐ Inside 50%

☐ Outside fenced yard ☐ Outside acreage/farm ☐ Outside loose ☐ Goes to park ☐ Goes to beach

How active is your pet? ☐ Very ☐ Moderate ☐ A little ☐ Not at all **Describe activities** _____

Has your pet lived or traveled outside of the Monterey Bay area? ☐ Yes ☐ No **If yes, where and when?** _____

Do you get pet care advice and/or does your pet receive care from anyone other than the veterinarian listed? ☐ Yes ☐ No

If yes, who? ☐ Pet store ☐ Family/friends ☐ Nutritionist ☐ Chiropractor ☐ Other: _____

Does your pet receive any treatments not prescribed by your veterinarian? ☐ Yes ☐ No

If yes, what? ☐ Vitamins ☐ Other nutrient supplements ☐ Herbs ☐ Extracts ☐ Massage ☐ Chiropractic ☐ Homeopathic

☐ Rieke ☐ Medications prescribed for another pet ☐ Human medications ☐ Other: _____

What else do you think we need to know? _____