West Madison Veterinary Hospital

YOUR "OTHER" FAMILY DOCTOR

Client Information

Date:____/____/_____

Owners Name(s): _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Birthdate: ____/_____/_____ Email: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Number of Pets (please specify type): _____

Pet Health History

Pet's Name: _____ Birthdate/Age:_____

Type: (Please circle one) Dog / Cat / Other Breed: _____

Sex: (Please circle appropriate) Male / Female Neutered / Spayed Date: ___/____/_____

Current Medications your pet is taking: _____

_____

Which clinic did your pet last visit?: _____ Date: ___/____/_____

Vaccinations: Distemper Date: ___/_____/_____ Rabies Date: ___/____/_____ Bordetella Date: ___/____/_____

Laboratory: Heartworm Test Date: ___/_____/_____ Fecal Test Date: ___/____/_____

Primary reason for visit today: _____

_____

Symptoms your pet is demonstrating (please circle all that apply):

Appetite Loss	Diarrhea	Loss of Balance	Thirst
Behavioral Changes	Eye Disorders	Scooting	Urination Increase
Breathing Problems	Gagging	Scratching	Vomiting
Coughing	Gums Bleeding	Shaking Head	Weakness
Depression	Limping	Sneezing	Other: _____

Prior Surgeries: _____

Prior Illnesses: _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that all professional fees are due at the time services are rendered.

Signature of responsible party: _____ Date: ___/____/_____