## Patient Information

Pet's Name: _____ Species (circle one): Dog Cat Other

Male ▪ or Female ▪ / Spayed ▪ or Neutered ▪ Date spayed or neutered _____

Breed:_____ Birthday/age: _____

Color/description:_____ Microchip ID: _____

Date Obtained: _____ Where did you obtain your pet? _____

Have you owned pets previously? Yes ▪ No ▪ Are there other pets in the home? Yes ▪ No ▪

If there are other pets Please indicate the species and number of each: Dogs (#) _____ Cats (#) _____

Birds (#) _____ Reptiles (#) _____ Other (Species & #) _____

On average, how much time does your pet spend outside? _____ (hours). Do any other pets go outside? _____

What do you feed your pet? How much per day? _____

Any vitamins or supplements? How much per day? _____

Any Medications? What dosage? For how long? _____

Has your pet ever had a reaction or a medication, vaccination or other product? If so what and when? _____

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