

# *New Patient Registration Form - Countrycare Animal Complex*

Owner: \_\_\_\_\_ Date: \_\_\_\_\_

## **Pet Information**

Pet's Name: \_\_\_\_\_ Species:  Dog  Cat  Other \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex:  Male  Neutered  Female  Spayed At what age did you obtain your pet? \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_  Actual Birthdate  Estimated Birthdate

Pet received from where?  Breeder - City/State: \_\_\_\_\_  Newspaper Ad  Friend/Relative

Humane Society \_\_\_\_\_  Rescue Group \_\_\_\_\_  Other \_\_\_\_\_

Does your pet have pet insurance?  No  Yes Company: \_\_\_\_\_ Policy # \_\_\_\_\_

## **Medication History**

Current medications (with dosage & frequency): \_\_\_\_\_

Current supplements (with dosage & frequency): \_\_\_\_\_

Any previous reaction to a medication?  No  Yes - List medication & reaction \_\_\_\_\_

Any previous reaction to a vaccination?  No  Yes - List vaccine & reaction \_\_\_\_\_

## **Medical History**

Summary of current medical conditions: \_\_\_\_\_

Medical Records can be obtained from which Veterinary Clinic(s)?

Pet's Name: \_\_\_\_\_ Owner: \_\_\_\_\_ Date: \_\_\_\_\_

**Current Symptoms**

Check the box of any/all symptoms or problems that you have noticed about your pet recently:

		Doctor Notes
<p><b><u>General</u></b></p> <p><input type="checkbox"/> Increase in weight</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Lack of energy</p> <p><input type="checkbox"/> Increase in energy</p>	<p><input type="checkbox"/> Increase in appetite</p> <p><input type="checkbox"/> Decrease in appetite</p> <p><input type="checkbox"/> Increased drinking</p> <p><input type="checkbox"/> Decreased drinking</p>	
<p><b><u>Skin</u></b></p> <p><input type="checkbox"/> Scratching</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Skin / body odor</p>	<p><input type="checkbox"/> 'Scooting' rear end</p> <p><input type="checkbox"/> New lumps / bumps Where? _____</p>	
<p><b><u>Ears:</u></b></p> <p><input type="checkbox"/> Head shaking</p> <p><input type="checkbox"/> Ear discharge    Left    Right</p>	<p><b><u>Eyes:</u></b></p> <p><input type="checkbox"/> Vision problems</p> <p><input type="checkbox"/> Eye discharge    Left    Right</p>	
<p><b><u>Respiratory:</u></b></p> <p><input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Gagging/drooling</p> <p><input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Excessive panting</p> <p><input type="checkbox"/> Labored breathing</p>	<p><b><u>Urinary:</u></b></p> <p><input type="checkbox"/> Excessive urination</p> <p><input type="checkbox"/> Straining to urinate</p> <p><input type="checkbox"/> Incontinence/dribbling</p> <p><input type="checkbox"/> Blood in urine</p>	
<p><b><u>Digestive</u></b></p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea / Loose stool</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Belching</p> <p><input type="checkbox"/> Excessive gas / flatulence</p>	<p><b><u>Teeth/Oral Cavity:</u></b></p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Tooth loss</p> <p><input type="checkbox"/> Difficulty eating / drinking</p> <p><input type="checkbox"/> Lack of appetite</p> <p><input type="checkbox"/> Gums bleeding / red</p>	
<p><b><u>Orthopedic:</u></b></p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Swellings</p> <p><input type="checkbox"/> Toenail problems</p> <p><input type="checkbox"/> Limping - which leg? _____</p>	<p><b><u>Neurologic:</u></b></p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Loss of balance/dizzy</p> <p><input type="checkbox"/> Shaking</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Head tilt</p>	
<p><b><u>Behavior:</u></b></p> <p><input type="checkbox"/> Fears / Anxiety</p> <p><input type="checkbox"/> Aggression</p> <p><input type="checkbox"/> Inappropriate urine/stool</p> <p><input type="checkbox"/> Other: _____ _____</p>	<p><b><u>Any other concerns?</u></b></p> <p>_____</p> <p>_____</p> <p>_____</p>	