

# Adair County Animal Hospital Online Patient History Form

Appointment Date: \_\_\_\_\_

<b>Client Name:</b>		<b>Patient Name:</b>	
<b>Address:</b>		<b>Weight:</b>	
		<b>Sex:</b>	
<b>Telephone:</b>		<b>Breed:</b>	
	CELL? or HOME?	<b>Age:</b>	

**Reason for Today's Visit / Client Concerns:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patient History:**

<b>Eating?</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Drinking?</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Urination?</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Defecation?</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Vomiting?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diarrhea?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Coughing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sneezing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Itching /Scratching?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Biting / Licking?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pain/ Lameness?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Activity Level?</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Any Known Allergies?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Brand of Heartworm Prevention?</b>	Refill needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Last given, when?</i>	
<b>Brand of Flea / Tick Prevention?</b>	Refill needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Last given, when?</i>	
<b>Other Current Medications:</b>	Refill needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(please list)</i>	