YOUR PET(s) MEDICAL HISTORY

Please complete all information of your PET(s)

PLEASE PRINT CLEARLY

	PET #1	PET #2	PET #3
Name			
Species (Cat, Dog, Other)			
Breed			
Description (Color)			
Date of Birth			
Sex			
Length of Ownership			
Altered/Spayed (Yes or No)			
Vitamins (Type)			
Diet (Type of Pet Food)			
Type of Grooming Products			
Hours spent outside each day			
Vaccinations (Yes, No or Don't Know Doctor)			
DHLP (Distemper-Dog)			
Parvovirus (Dog)			
FVRCP (Infectious Diseases-Cat)			
Rabies (Dog/Cat)			
Feline (Cat) Leukemia Tested?			
Any Other Vaccines?			
Heartworm Tested?			
Under Heartworm Prevention?			
Fecal Exam? (Worms-Dog/Cat)			
Under Dental Care?			
Any Prior Illness?			
Any Prior Surgery?			

If you would like your records transferred, please provide us with the name and telephone # of your PET(s) last Veterinarian.

Name:_____

Telephone: (_____) _____

Is there anything else we should know about?:

_____

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