Family Veterinary HOSPITAL

Office use only:

- ☐ entered
- ☐ picture
- ☐ thank you
- ☐ microchip

CLIENT INFORMATION

Date:_____

Name:_____ Significant Other:_____

Address:_____Apt. no._____

City:_____State:_____ Zip Code:_____

Home Phone:_____Cell/Alternate:_____

Spouse/Significant Other Phone_____

E-mail address:_____

How did you hear about us? Please check all that apply.

- ☐ Friend/FVH client:_____
- ☐ Website
- ☐ Internet
- ☐ Sign/drive by
- ☐ DAVMS Booklet
- ☐ Chow Down
- ☐ Bergen Bark Inn
- ☐ Facebook
- ☐ Other:_____

Pet's Information

Name: _____Breed:_____Color:_____ Microchip? Y N

Age:_____ Sex:_____ Has your pet been spayed or neutered? Y N

Date of last vaccinations:_____ What do you feed your pet?_____

Name: _____Breed:_____Color:_____Microchip? Y N

Age:_____ Sex:_____ Has your pet been spayed or neutered? Y N

Date of last vaccinations:_____ What do you feed your pet?_____

Kevin Inman DVM • Elizabeth Lawrence DVM, MS • 3951 Evergreen Parkway • Evergreen CO 80439
phone 303.679.VETS (8387) • fax 303.313.1671 • www.evergreenfamilyvet.com

Family Veterinary HOSPITAL

Pet's Name: _____

During today's visit your pet will have a thorough physical exam completed by your veterinarian. Our goal is to identify problems that may be early in developing, and treat any concerns that may already be present. Please answer the following questions to help us establish your pet's health history. This helps us to increase the likelihood of a longer, more comfortable and active life for your pet.

Have you noticed:

- ☐ A change in appetite?..... NO YES
- ☐ Weight gain or weight loss?..... NO YES
- ☐ Excessive itching or scratching?..... NO YES
- ☐ Lumps or bumps?..... NO YES
- ☐ Dental problems (bad breath, tartar, blood in mouth)?..... NO YES
- ☐ Stiffness on rising, less willing to jump in the car?..... NO YES
- ☐ Decrease in energy level?..... NO YES
- ☐ Coughing, sneezing or difficulty breathing?..... NO YES
- ☐ Vomiting?..... NO YES
- ☐ Change in bowel movements (consistency or frequency)?..... NO YES
- ☐ Change in drinking/urination (circle-less or more)?..... NO YES
- ☐ Eye problems (vision change, discharge)?..... NO YES
- ☐ Ear problems (head shaking, scratching, odor, discharge)?..... NO YES
- ☐ Fleas or ticks?..... NO YES
- ☐ Do you board your pet, take to daycare or grooming?..... NO YES
- ☐ For Dogs: travel out of state?.....Monthly heartworm preventative?..... NO YES
- ☐ For Cats: does your cat go outdoors or come in contact with other cats?..... NO YES

Please list all medications, supplements that your pet currently receives:

_____

_____

What do you feed your pet, how often and how much? _____

Please mention any concerns you have that are not on this list to your veterinarian.

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