



Veterinary Questionnaire

Client _____ Date of last visit ___/___/___
 Pet name _____ Age _____ Spayed/Neutered: Y/N

Has this pet ever been diagnosed or treated for any of the following- Check all that apply

<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	Skin Allergies
<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Dysplasia (hip/elbow/etc)	<input type="checkbox"/>	GI Issues
<input type="checkbox"/>	Separation Anxiety	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Chronic Ear/Eye Infections	<input type="checkbox"/>	Hot Spots
<input type="checkbox"/>	Upper Respiratory Conditions	<input type="checkbox"/>	Kidney Disease

Detail any of the checked boxes below

List any current medications with dosages

_____ _____

List any other chronic conditions

What is the pets overall condition

<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good
<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor

The animal described above has been inspected by me and to the best of my knowledge is free of any infectious or uncontrolled chronic illness that may endanger the animal or other animals or would endanger public health.

Signed _____ Date _____
 Veterinary Practice _____