alta animal hospital

Pet Name ____________________

Comprehensive Patient Medical History Form

	Yes	No
Is your pet microchipped?		
Is your address and phone number still correct?		
Do you have pet health insurance?		
Are your pet's vaccinations up to date?		
Is your pet spayed or neutered?		
Was there a heartworm test in the last year?		
Is your pet taking heartworm prevention Rx?		
Has your pet been tested for worms in the last year?		
Have you seen your pet passing any worms?		
Has your pet had any illness/injury in the last year?		
Has your pet ever had a seizure?		
Does your pet get table scraps?		
Did your pet eat in the last four hours?		
Does your pet ever strain to urinate?		
Has there been any recent vomiting?		
Has your pet been coughing?		
Has your pet been sneezing?		
Has your pet been gagging?		
Any listlessness?		
Any weakness?		
Any lameness? Circle leg RF LF RR LR		
Shaking of the head?		
Scratching? Where?		
Significant hair loss?		
Scooting of rear?		
Unusual lumps or bumps?		
Bad breath?		
Unusual discharge?		
Diarrhea?		
Constipation?		
Stiffness?		
Behavioral changes?		

	Increased?	Decreased?
Drinking?		
Appetite?		
Urination?		
Defecation?		
Weight?		

Reason for visit today

____

____

____

Has your pet been examined elsewhere for the same condition? Yes No

If so, where? ____________________

What medications is your pet now taking?

____

____

Is your pet allergic to any foods or Rx? Y N

If yes, please describe ____________________

____

What flea control is used?

____

Anything else we need to know?

____

____

____

____

____

____

I hereby authorize the hospital to prescribe for and treat the conditions presented on this form for the pet presented by me. The hospital and staff will not be held liable for any problems that develop provided that reasonable care is provided. Further I agree to pay fees in full for services rendered when pet is discharged from the hospital's care unless other prior arrangements have been agreed upon by both parties.

____________________ ____________________

Signature Date

CLIENT REGISTRATION FORM

MR.
MRS.
MISS

TODAY'S DATE ______________

LAST NAME ______ FIRST NAME ______ MIDDLE NAME ______ SPOUSE'S FIRST NAME ______

ADDRESS ______
NUMBER ______ STREET ______ CITY ______ ZIP CODE ______ HOME PHONE ______

OCCUPATION OR TITLE ______ WORK PHONE ______ EXTENSION

EMPLOYER ______
NAME ______ STREET ______ CITY ______ PHONE ______ HOW LONG HERE ______

SPOUSE'S EMPLOYER NAME ______ STREET ______ CITY ______ PHONE ______ OCCUPATION ______

REFERRED BY: ______ SOCIAL SEC. NO. ______ DRIVER'S LIC. NO. ______

PET'S NAME	SPECIES	PET'S NAME	SPECIES	PET'S NAME	SPECIES
BREED	COLOR SEX M F	BREED	COLOR SEX M F	BREED	COLOR SEX M F
BIRTHDATE	AGE THIS DATE [ ] ALT. [ ] SP	BIRTHDATE	AGE THIS DATE [ ] ALT. [ ] SP.	BIRTHDATE	AGE THIS DATE [ ] ALT. [ ] SP.
DATE OF LAST VACCINATION OR BOOSTER		DATE OF LAST VACCINATION OR BOOSTER		DATE OF LAST VACCINATION OR BOOSTER	
DHLP / /	RABIES / /	DHLP / /	RABIES / /	DHLP / /	RABIES / /
PARVO / /	PANLEUKOPENIA (FELINE DISTEMP.) / /	PARVO / /	PANLEUKOPENIA (FELINE DISTEMP.) / /	PARVO / /	PANLEUKOPENIA (FELINE DISTEMP.) / /
PNEUMONITIS / /	FVRC / /	PNEUMONITIS / /	FVRC / /	PNEUMONITIS / /	FVRC / /
RHINO/CALICI (UPPER RESP) / /	OTHER / /	RHINO/CALICI (UPPER RESP) / /	OTHER / /	RHINO/CALICI (UPPER RESP) / /	OTHER / /

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME THEY ARE RENDERED. PLEASE CIRCLE YOUR METHOD OF PAYMENT:

CASH CHECK VISA M/C ☐ ______

SIGNATURE OF OWNER ______ ☐ ______

SIGNATURE OF PERSON PRESENTING THIS PET FOR TREATMENT IF OTHER THAN OWNER ______

☐SON/DAU. ☐PARENT
RELATIONSHIP TO OWNER ☐ ______

ADDRESS OF NON OWNER ______ PHONE ______