Medical History Checklist for Canine and Feline Patients

Date______________________ Technician___________________________________________________

For all patients

☐ Chief complaint or reason for visit?

☐ Any vomiting? Yes/No
  ☐ When did it start?
  ☐ How soon before or after eating does the vomiting occur?
  ☐ Is the food digested? Yes/No
  ☐ Are there any foreign items in the vomit? Yes/No If yes please describe

☐ How frequently are they vomiting?

☐ What is the consistency of the vomit?

☐ Could they have eaten something inappropriate? Yes/No If yes please describe

☐ Have you recently changed the diet? Yes/No If yes please describe change

☐ Any diarrhea? Yes/No
  ☐ When did it start?
  ☐ How often are they having diarrhea?
  ☐ Is there any blood or mucus in the stool? Blood Yes/No Mucus Yes/No
  ☐ Describe the consistency?
  ☐ What is the volume of stool?
  ☐ Have you recently changed their diet? Yes/No
    ▪ If yes when did the change occur?
    ▪ What is the name of the old and the new food?
  ☐ Could they have eaten anything inappropriate? Yes/No
    ▪ If yes what and when?

☐ Any coughing? Yes/No
  ☐ When did it start?
  ☐ How often do they cough?
  ☐ Describe the cough? Dry/hacking, productive, high pitch wheeze
  ☐ Did the patient loose conciseness before, during or after the cough? Yes/No
    ▪ If yes, for how long?
    ▪ Did you notice their mucus membrane color? White/pink/red/purple

☐ Any sneezing? Yes/No
  ☐ When did it start?
  ☐ Is it constant or intermittent?
  ☐ Is there any nasal discharge? Yes/No
If yes, clear/mucus/greenish yellow/hematuria

☐ Does the patient spend any time outside unattended? Yes/No

☐ Is the patient urinating as he/she normally does? Yes/No
  ☐ When did it start? ________________________________
  ☐ Is the change daily? Yes/No
  ☐ Has the urine production increased or decreased?
  ☐ When was the last time they produced urine? ________________________________
  ☐ Is there any straining? Yes/No
  ☐ Do they ever posture and not produce any urine? Yes/No
  ☐ Is the odor stronger than normal? Yes/No
  ☐ What is the color? Amber/transparent/hematuria

☐ Any change in water consumption? Yes/No
  ☐ Are they drinking more or less water?
  ☐ When did it start? ________________________________
  ☐ Do they share their water bowl with another pet? Yes/No
  ☐ How often do you change the water in one day? ________________________________
  ☐ Has anything changed at the time of the water intake changing? Yes/No
    Diet/weather/visitor at home/new baby/new pet/new home/vacation/prescriptions/over the counter supplements

☐ Any change in food intake? Yes/No
  ☐ Describe the change? ________________________________
  ☐ When did it start? ________________________________
  ☐ Has anything changed at the time the food intake changed? Yes/No
    Diet (if diet, describe change)/weather/visitor at home/new baby/new pet/new home/vacation/prescriptions/over the counter supplements

☐ What diet are they on? ________________________________

☐ Do they get snacks and if so what kind and how often? ________________________________

☐ What is the patient's exercise tolerance like? ________________________________
  ☐ a. Has it changed? Yes/No
  ☐ c. In what way has it changed? ________________________________
  ☐ d. When did you first notice the change? ________________________________
  ☐ e. Has the change regressed, progressed or is it stable?

☐ Describe the patient's general attitude? BAR/QAR/timid/outgoing/couch potato

☐ Are you happy with their attitude? Yes/No

☐ Have you seen any behavior changes? Yes/No
  ☐ Describe the change? ________________________________
  ☐ Eliminating in the house? Yes/No
  ☐ Having to go out to eliminate more often? Yes/No
  ☐ No longer sleeping through the night/sleeping pattern changed? Yes/No
  ☐ No longer coming when called? Yes/No
  ☐ Seems depressed or has become more active?
□ ANY sign of aggression? Please describe in detail? Whom is the aggression towards?

□ Have they ever taken any type of obedience training? Yes/No

□ Are there any changes in their environment? New house/new pets/ additional humans at home/someone’s moved away/death in family

□ Are they taking any prescribed medication? Yes/No

□ When was the medication last taken? ________________

□ Is the prescribed medication from this hospital? Yes/No If no please list medication name, dose, and name of prescribing veterinarian.

□ Are they taking any OTC medication or supplements? Yes/No If yes please list all names, doses and the last time they were taken.

□ Has the patient had any medical treatment or any surgery at another Veterinary hospital? Yes/No If yes please describe the treatment and/or surgery, and provide the date and hospital name. ________________________________

Some questions for ill or injured patients; pick the questions that are appropriate

□ When did the illness/injury begin? ____________________________________________

□ Were you present when the injury occurred? Yes/No

□ How far did they fall? ________________________________________________

□ Did anything fall on top of them? Yes/No Describe __________________________

□ Which limb if any did you notice them limp on? ____________________________

□ Did the patient lose consciousness? Yes/No If yes for how long? ________________

□ HBC

□ Did the vehicle hit the patient or physically run over the patient?

□ Was the patient ever pinned under the car or dragged by the car? Yes/No

□ Was the patient ever able to stand on their own after being hit? Yes/No

□ BW

□ Do you know what type of animal was involved? Yes/No Describe __________________

□ Did the animal pick up and/or shake your pet? Yes/No

□ Do you know the owner of the pet who did the biting? Yes/No

□ Did you get bit? Yes/No If yes advise owner to seek medical attention.

□ Did the other animal get bit by your pet? Yes/No

□ Is the biting pet current on rabies vaccine?

□ ADR
☐ Could they have eaten something not intended for cats/dogs? Yes/No If yes please describe ____________________________________________

☐ Is anything missing that could have been eaten? Yes/No If yes please describe________________________

☐ Does the patient have the tendency to get into the trash? Yes/No
☐ Does the patient have access to the trash? Yes/No
☐ Does the patient spend time outside unattended? Yes/No
☐ Has anyone changed the antifreeze on a car at a location the pet has access to? Yes/No

☐ At any point did your pet seemed dazed, confused or off balanced? Yes/No
☐ Did your pet relieve himself in an inappropriate place? Yes/No