



Animal Medical Center
of North Ottawa

We're excited to know more about your pet! (please do tell us!)

Every pet has different health needs. Please answer the following questions so we may determine your pet's needs, make suggestions to improve the quality of your pet's life, and assess your pet's risk level in many different areas.

Pet Information

Pet's Name _____

Dog Intact Male Breed _____
 Cat Neutered Male Color _____
 Other (below) Intact Female Date of Birth _____
 Spayed Female

When did your pet have it's last vaccinations: _____

If you know which vaccines were given, please circle them:

Dogs: Rabies Distemper Kennel Cough Lyme

Does your pet have any prior illnesses or injuries we should know about?

Cats: Rabies Distemper Feline Leukemia FIV

If yes, please describe _____

Have you medicated your pet recently? (including over the counter drugs)

If yes, state medications _____

Where did you get your pet from? _____ How long have you owned your pet? _____ years months
(circle one)

On average, how many hours a day is your pet outside? _____ How often do you bath your pet? Every _____ weeks months
(circle one)

What brand food does your pet eat? _____ canned dry Where does your pet sleep? Indoors Outdoors
(circle one) (circle one)

Dogs:
When was your dog last tested for heartworms? _____

Cats:
Has your cat ever been tested for Feline Leukemia and Feline AIDS? No Yes If so, when? _____

| | | | |
|---|--|--|--|
| Do you take your pet to a groomer? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Does your pet have a microchip ID?# _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you board your pet at certain times of the year? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Has your pet ever had dental care? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Does your pet have any drug allergies? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Do you plan on having your pet neutered? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Does your pet spend long periods of time alone? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Is your pet on a flea and tick prevention program? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you use your pet for hunting or sporting? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Is your pet on an intestinal worm preventative? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you plan to breed your pet? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Is your pet on a heartworms preventative pill? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Does your pet get table food? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Has your pet ever had a urine analysis? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Please check any of the following that are a problem:

| | | |
|---|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Houstraining/ Litterbox | <input type="checkbox"/> Difficulty getting up |
| <input type="checkbox"/> Coughing/ Sneezing | <input type="checkbox"/> Itching/ Scratching too much | <input type="checkbox"/> Excessive water consumption |
| <input type="checkbox"/> Vomitting | <input type="checkbox"/> Straying from home | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Diarrhea/ Loose Stools | <input type="checkbox"/> Biting | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Ear Infections/ Itchy Ears | <input type="checkbox"/> Odor | <input type="checkbox"/> Painful (location) _____ |

Please list any other concerns or questions you may have that we can answer for you.

