One Love Animal Hospital

If you love your pet as much as you love yourself, then One Love is the place for you.

CHRONIC/PERSISTENT ILLNESS/INJURY VISIT QUESTIONNAIRE

Date: _____ Owner: _____

Pet Name: _____

Your pet is undergoing treatment for? _____

Since your last visit, has your pet experienced any of the following?

Hospitalization or emergency treatment at another facility ☐Yes ☐No

If yes, what is the name of this facility? _____

When did this occur? _____

Was the cause of this emergency care related to your pet's ongoing illness? ☐Yes ☐No

If no, what was the nature of this visit? _____

Was your pet prescribed any medication? ☐Yes ☐No, and is your pet still taking this medication? ☐Yes ☐No. If you answer yes to both of these questions, list the medication under CURRENT MEDICATIONS.

Serious illness/injury ☐Yes ☐No

If yes, list the illness/injury_____

Surgeries/Dentals/Procedures ☐Yes ☐No

If yes, list the procedure_____

Changes to home/environment ☐Yes ☐No. Please describe. _____

_____

_____

Travelled outside of the greater New York area ☐Yes ☐No Where to? _____

For how long? _____ Mode of transportation: ☐Car ☐Plane ☐Other _____

Changes in activity level ☐Increase ☐Decrease ☐No change.

PHYSICAL SYMPTOMS (*Check all that apply and indicate if any are new since your last visit.*):		
☐ **Asthma**	☐ **Difficulty eating/Dropping food**	☐ **Limping**
☐ **Bad Breath**	☐ **Excessive thirst**	☐ **Not eating**
☐ **Bleeding**	☐ **Exercise intolerance**	☐ **Pain/Sensitivity**
☐ **Breathing problems**	☐ **Flatulence**	☐ **Seizures**
☐ **Bruising**	☐ **Frequent urination**	☐ **Sneezing**
☐ **Coughing**	☐ **Hair loss**	☐ **Vision changes**
☐ **Constipation**	☐ **Itching**	☐ **Vomiting**
☐ **Diarrhea**	☐ **Lethargy**	☐ **Weakness**
☐ **Behavioral changes:**		
☐ **Injury/Trauma. Where?**		
☐ **Other:**		

Have the symptoms from your last visit: ☐Increased? ☐Decreased? ☐No change.

If your pet's symptoms have changed since your last visit, briefly describe the nature of the change. Please indicate whether or not these changes occurred in conjunction with change in medication, diet, environment, and/or activity._____

_____

_____

_____

_____

If your pet is experiencing new symptoms, when did they first occur?

_____
_____
_____

CURRENT MEDICATIONS (*Please indicate if any medication was prescribed by another clinician since your last visit. Use reverse side if necessary.*):		
Name of Medication:	**Dose (*mg/day, ml/day, tablets/day*):**	**Date started/purpose:**

Do you give heartworm and flea/tick preventative? □None □Yes, Brand(s)_____
Date last given?_____
Do you give any supplements/vitamins?_____

OTHER INFORMATION:
Please list any further information or questions concerning your pet's health.

I certify that the above information is correct to the best of my knowledge and that I have not purposefully misrepresented my pet's health history. If applicable, I will notify One Love Animal Hospital of any changes to my pet's medical condition, and furnish them with a copy of my pet's medical records at the time of my appointment. I will not hold any member of One Love Animal Hospital responsible for errors or omissions that I may have made in completing this form.

_____ _____
(Owner's Signature) (Date)