

Animal Health History

PERSONAL INFORMATION			
Owner:		Date:	
Owner Phone #:		Cell #:	

Species: _____ Breed: _____

Animal ID: _____ Colors/Markings: _____

Sex: _____ Neutered/Sprayed: _____ DOB: _____ Age: _____

Wt: _____ Appetite : _____ BM: _____ Water: _____

VITALS			
Pulse:		Temperature:	
		Respiration:	

SYMPTOMS			
<input type="checkbox"/> Coughing	<input type="checkbox"/> Scours	<input type="checkbox"/> Ear Odor/Discharge	<input type="checkbox"/> Eye Discharge
<input type="checkbox"/> Lethargy	<input type="checkbox"/> Lesions	<input type="checkbox"/> Limping	<input type="checkbox"/> Scratching
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Coughing	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Difficulty Urinating
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Increased Urine	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss

Other Symptoms:
Duration of Symptoms:
Frequency of Symptoms:
Observation:
Treatment:

