Gwinnett Animal Hospital
Small Animal Holistic Patient Record

Patient Name:_____ Breed:_____ Species:_____

Weight:_____ Date of Birth:_____ Sex:_____ Altered? Y / N

Address:_____ Telephone:_____

_____ E-mail:_____

Major Complaint:_____

_____

How long has your pet had this problem?_____

What do you feed your pet? What are the ingredients?_____

_____

Does your pet prefer to lie in the sun or on cool tiles?_____

Is your pet thirsty, not thirsty, or has normal thirst?_____

Does your pet have a poor, normal, or ravenous appetite?_____

Is your pet on supplements or drugs? If so, please list dosages and frequency given:_____

_____

Does your pet have diarrhea?_____ If so, is it bloody and smelly, or watery with no blood?_____

If your pet has vomiting or diarrhea how frequently and what circumstances cause them to do so?_____

Has your pet ever had any reactions after receiving vaccines? (immediately or within 4 days)__

_____

Is your pet's personality hyperactive, outgoing, confident, strong or quiet, timid, and less confident?_____

Is your pet urinating normally, less frequently, or more frequently than normal?_____

_____ Is the color yellow, bloody, or clear?_____

Does your pet sleep quietly at night or dream frequently?_____

Does your pet wake frequently at night? If so, what time of the night?_____

_____

Does your pet enjoy massage, or react painfully when you pet it? _____

If painful, which area?_____

Can your pet walk normally, or does it have difficulty walking? If so, which leg(s) appear to be affected?_____

Does your pet have good energy or is it low in energy? If so, for how long has the energy been decreased?_____

Please use the rest of this page to write any history or problems that you feel are important for us to know about your pet.

Submit