CROTON ANIMAL HOSPITAL

PATIENT HISTORY FORM

Client Name:	**Patient Name:**
Date of Appointment:	**Contact number during appointment time:**

Within the last 14 days has the patient (pet) been in contact with anyone who was diagnosed with or had symptoms of COVID-19? Yes / No

Current Medical Issues You Would Like to Discuss					
☐Vomiting	☐Diarrhea	☐ Coughing	☐Sneezing	☐Drinking more	☐Urinating more
☐Decreased appetite	☐Decreased activity	☐Itching / Rashes	☐Shaking head and/or itching ear(s)	☐Eye discharge: L/R Squinting: L/R Rubbing: L/R	☐Limping: Front / Rear Right / Left

DESCRIBE MEDICAL COMPLAINT IN DETAIL – when it started / changes over time / improving or worsening

Use back of page if needed.

DIET	
Brand (canned or dry)	How much and how often?

LIST CURRENT MEDICATIONS including dose and frequency of administration
• Heartworm Preventative • Flea & Tick Preventative • Supplements

Please remain in the parking lot while your pet is in the hospital. Thank you!