Oncology: IOC Medical History Form

Owner's Name *

First Name Last Name

Email *

example@example.com

Patient Name

Species

Canine Feline

Breed

Color

Sex

Male

Female

How long have you owned your pet?

Where is your pet housed?

Indoors Outdoors Both

Purpose of animal?

Pet Show Sport Guard Service

For intact females: When was her last heat cycle? (approx.)

For neutered/spayed pets: When was surgery performed? (approx.)

What is your pet's current diet? (Use brand names, please)

Does your pet have contact with other animals?

Yes No

Has your pet ever traveled outside of southeastern Michigan?

Yes No

If yes, where?

What medications is your pet currently receiving, including heartworm and flea preventative?

Has your pet had any adverse reactions to any medications?

Yes

No

If yes, which medications?

What illnesses, injuries or surgeries has your pet had prior to the current problem?

Is your pet currently coughing or sneezing?

- Coughing
- Sneezing

Has there been any recent changes in your pet's willingness to play or exercise?

Yes

No

Is your pet currently vomiting?

Yes

No

Has there been a recent change in your pet's appetite?

Yes

No

Has your pet lost or gained weight recently?

- Loss
- Gain
- No change

Has there been any recent change in your pet's bowel movements?

Yes

No

Has there been any recent change in your pet's urinary habits?

Yes

No

If yes, more or less?

More

Less

Have you noticed a change in the amount of water your pet drinks?

Yes

No

If yes, more or less?

More

Less

Please list any medications which have been successfully or unsuccessfully used to treat the condition your pet is presenting for today and your pet's response to these treatments

Please list all current supplements and herbs your pet is taking

Please specify the reason your pet is presenting to for consultation today and your primary concern

What are your treatment goals? What would you like to achieve with therapy?

Other comments: