GULF COAST VETERINARY SPECIALISTS

Gulf Coast Veterinary Neurology and Neurosurgery
Patient Medical History

Label

DATE: _____

How long have you owned your pet? _____

Where was your pet obtained? _____

Has your pet traveled out of state in the past two years?
Yes No Unknown

If yes, where? _____

Has your pet ever had ticks? Yes No Unknown If yes, when?_____

Is your pet kept primarily outdoors or in the house? _____

What kind of food do you feed your pet?_____

How much per day?_____

What types of snacks/treats do you feed your pet and how often? _____

Is your pet ever fed table food? _____

Do you have other pets? No___ Yes___ What breeds or species? _____

_____

Has your pet been boarded or hospitalized recently? Yes No Unknown

If your pet is neutered, what was his/her age at alteration? _____

Has your pet had any previous surgery other than spay or neuter?

No ____ Yes _____What kind of surgery?_____.

If female and not neutered, when was her last heat? _____

If female, has she had any litters? Yes No Unknown

If yes, when? _____

Describe your primary concern(s) about your pet. _____

_____

_____

When did this problem(s) begin? _____

What symptoms have you observed at home? _____

_____

How long have the symptoms been present? _____

Did the symptoms start suddenly? _____

Are the symptoms: Progressing____ Staying the same____ Improving____

Is your pet otherwise normal? Yes____ Or are there other medical problems we need to know about?

_____

_____

Is your pet on any medication? No____ Yes____

If Yes, What medication(s) is your pet currently taking for this problem?
_____

What medication has your pet taken for this problem in the past: _____

If medications are being used to treat the condition for which we are evaluating your pet, have they been associated with any improvement in the condition?_____

_____

Have medications been previously used that were NOT successful? _____

Please list ALL medications your pet currently takes for UNRELATED problems: _____

_____

Has your pet had any unexpected reactions to medications?	Yes	No	Unknown
Has your pet received aspirin or Ascriptin during the past six months.	Yes	No	Unknown
Has there been a change in your pet's appetite?	Yes	No	Unknown
If yes, is it **increased** or **decreased?** (circle one)			
Has there been a recent change in your pet's weight?	Yes	No	Unknown
If yes, has it **increased** or **decreased?** (circle one)			
Has there been a change in your pet's water consumption?	Yes	No	Unknown
If yes, is it **increased** or **decreased?** (circle one)			
Is your pet urinating more frequently than normal?	Yes	No	Unknown
Has your pet been straining to urinate?	Yes	No	Unknown

Have you noticed your pet vomiting? Yes No Unknown

If yes, what is the frequency? _____

Has there been a change in your pet's bowel movements?	Yes	No	Unknown

If yes, describe the appearance (color and consistency) _____

What is the frequency of defecation? _____

Has there been any straining to defecate?	Yes	No	Unknown
Have you seen any blood in any urine, vomitus, or stool?	Yes	No	Unknown
Has your pet been scratching?	Yes	No	Unknown
Has your pet had any seizures or convulsions?	Yes	No	Unknown

Has there been a change in your pet's attitude or behavior?

If yes, describe: _____

_____

Has there been any change in your pet's walking? Yes No Unknown

Has your pet lost any stamina lately? Yes No Unknown

Have you noticed any abnormal swellings? Yes No Unknown

If yes, where? _____

Have you noticed any abnormal discharges or drainage? Yes No Unknown

If so, describe (eyes, nose, vulva; appearance). _____

_____

Has your pet had difficulty breathing? Yes No Unknown

Has your pet had any coughing? Yes No Unknown

If yes, circle the most appropriate description below:

The frequency is **occasional, frequent, or continuous.**

It occurs most often at **night, morning, exercise, excitement, or anytime.**

Would you describe the cough as **mild, moderate or severe**

FOR MRI PURPOSES DOES YOUR PET HAVE A MICROCHIP OR ANY METAL IMPLANTS?_____

PLEASE MAKE ANY ADDITIONAL COMMENTS ON THE REVERSE SIDE.