



All Pets Animal Hospital

Patient Information Sheet

Please complete the following information about your pet. The information given will help us provide the best care possible for your animal companion.

Date: _____ Client (Owner) Name: _____

Patient (Pet) Name: _____ Age or Birth Date: _____

Species (canine, feline, avian, etc.): _____ Breed: _____

Sex (please choose): _____ Spayed/Neutered: _____

Color: _____ Distinguishing Marks: _____

Is Your Pet Microchipped: _____ Microchip Number: _____

*Previous Veterinarian: _____ May We Call for Records? _____

Known Aggressive/Nervous Tendencies: _____

Known Medical Conditions: _____

Known Allergies: _____

Significant Medical History: _____

Other Comments: _____

Vaccine/Medical History (please give date of last vaccination, if applicable):

Canine DA(H)PP: _____ Bordatella: _____ Rabies: _____ Heartworm Test: _____

Is your dog on Heartworm Medication?

Is your Pet on Flea Control:

Feline: FVRCP: _____ FeLV: _____ Rabies: _____

What is your cat's FeLV/FIV Status: _____

Is your Cat on Flea Control:

Other: _____