



PATIENT INFORMATION

Please complete entire form.

Patient Name _____ Owner's Name _____

Canine Feline

Gender: Male Female

Neutered Spayed

Micro-Chipped: Yes No

Breed _____ Color _____

Birth Date/Approx. Age _____ How long have you owned this pet? _____

Where did you obtain pet? _____

Vaccination History:

| <u>CANINE Vaccine</u> | <u>Date Given</u> | <u>FELINE Vaccine</u> | <u>Date Given</u> |
|-----------------------|-------------------|-----------------------|-------------------|
| DA2PP | _____ | FVRCP | _____ |
| Rabies | _____ | Rabies (1year/3 year) | _____ |
| Bordetella | _____ | FeLV | _____ |
| Leptospirosis | _____ | | |
| Influenza | _____ | | |

Test History:

| <u>CANINE Test</u> | <u>Date Tested/Result</u> | <u>FELINE Test</u> | <u>Date Tested/Result</u> |
|---------------------|---------------------------|---------------------|---------------------------|
| Heartworm test | _____ | FeLV/FIV test | _____ |
| Fecal Parasite test | _____ | Fecal Parasite test | _____ |

Please rank the order of importance to you when choosing your vet:

_____ Appearance of building _____ Appearance of staff _____ Cost of services

_____ Caring doctors and staff _____ Staff that educates me _____ Hours

Previous Vet/Hospital _____ May we call for records? Yes / No

Any other pets in the house? _____

For staff use only:

- New Pet Card Sent
- PEAN Reminder Generated (Date of reminder: _____)
- Previous Records Brought in or Date Called _____ Initials _____