Country Veterinary Service

Curbside History Form

Owner's Name_____ Pet's Name: _____Best Contact # _____

What is your pet here for today? _____

Any known allergies? _____

Your pet's diet: Brand_____ Cup(s) per feeding ____ How many times daily _____

Any limping, pain stiffness or other mobility issues? _____

Current medications and/or supplements: _____

Is your pet on any preventatives? HEARTGARD PLUS / NEXGARD / FRONTLINE GOLD / REVOLUTION PLUS

Do you need refills? _____

Please check any changes that apply:

- ⇨ Appetite (increase/decrease)
  If so, explain_____
- ⇨ Thirst (increase/decrease)
  If so, explain_____
- ⇨ Defecation (normal/ soft/runny)
  If so, explain_____
- ⇨ Urination (increase/decrease/straining)
  If so, explain_____
- ⇨ Skin Issues (scratching/licking/chewing) (seasonal/year round)
  If so, explain_____
- ⇨ Ears (scratching/head shaking) (first time/chronic)
  If so, explain_____
- ⇨ Masses (location/ changes in size)
  If so, explain_____
- ⇨ Coughing (How long) (Worse with activity) (pattern to it)
  If so, explain_____
- ⇨ Sneezing (frequency/discharge present)
  If so, explain_____
- ⇨ Vomiting (When did it start/ dietary indiscretion)
- ⇨ Eyes (discharge/squinting/rubbing)
  If so, explain_____
- ⇨ Oral (smelly breath/ chewing on one side/ dropping food)
  If so, explain_____
- ⇨ Activity (lethargic)
  If so, explain_____

We advise geriatric bloodwork screening for all patients 6 years and older, if you <u>do not</u> want to pursue this, please check here ⇨.

Any other questions or concerns? _____

Authorization to treat your pet: _____ Date: _____