

Please fill out information as applicable and bring along any previous medical records when you visit.	Pet #1 NAME	Pet #2 NAME	Pet #3 NAME
	Circle one: K-9                      Fel	Circle one: K-9                      Fel	Circle One: K-9                      Fel
<b>BREED?</b>			
<b>COLOR?</b>			
<b>Date of Birth or Approximate Age?</b>			
<b>Male or Female?</b>			
<b>Neutered or spayed?</b>			
<b>Date of last Vaccinations?</b>			
<b>FOR DOGS: Date of last Canine DHPP Vaccination?</b>			
<b>Date of last Rabies Vaccination?</b>			
<b>Date of last Heartworm Test? Result?</b>			
<b>FOR CATS: Date of last Feline RCP Vaccination?</b>			
<b>Date of Feline Rabies Vaccine?</b>			
<b>Date of last Leukemia Vaccine?</b>			
<b>Date of Feline Leukemia/FIV Test? Result?</b>			
<b>Date of last Stool Check?</b>			

**Does your pet have any known allergies to medications or other substances?** \_\_\_\_\_

**Is your pet currently on any medications?** \_\_\_\_\_

**Has your pet had or been treated for any major medical problems?** \_\_\_\_\_