

NEUROLOGICAL CENTER FOR ANIMALS: GENERAL HISTORY

PET NAME _____

CASE NUMBER _____

OWNER NAME _____

DATE _____

At what age did you purchase your pet? _____

From where? _____

Has your pet lived or traveled outside Colorado? YES

NO

If YES, where and when? _____

Which best describes your pet's environment? INDOOR OUTDOOR INDOOR/OUTDOOR

Are there other pets in the household? _____ If YES, list _____

Your pet's diet _____ Number of meals per day _____

Did your pet receive a regular series of vaccinations when young? YES

NO

When was the last set of vaccinations given? Date _____ Vaccinations _____

Please list any previous major health problems or surgeries

Date _____ Problem or Surgery _____

Date _____ Problem or Surgery _____

Date _____ Problem or Surgery _____

Others _____

Please list all medications, vitamins, or nutraceuticals that you are giving your pet

Drug _____ Dose and Frequency _____ Date Started _____

Drug _____ Dose and Frequency _____ Date Started _____

Drug _____ Dose and Frequency _____ Date Started _____

Drug _____ Dose and Frequency _____ Date Started _____

List other drugs given in last 6 months? _____

Has your pet had any change in?

Appetite Increased Decreased Unchanged

Weight Increased Decreased Unchanged

Drinking Increased Decreased Unchanged

Urinating Increased Decreased Unchanged

Have you noticed any vomiting? YES NO

Have you noticed any diarrhea? YES NO

Have you noticed loss of bowel or bladder control? YES NO

Have you noticed any behavior change? YES NO

Have you noticed any seizures? YES NO

Is your pet sleeping more than normal? YES NO

Have you noticed any head, neck, or body tremors? YES NO

Is your pet weak or unable to walk on any of its limbs? YES NO

If YES, which limbs? LEFT FORE RIGHT FORE LEFT HIND RIGHT HIND

Have you noticed any painful areas in your pet? YES NO

If YES, where? _____