



Pershing Oaks Animal Hospital  
Patient History Form

Date \_\_\_\_\_ Owner Name: \_\_\_\_\_  
Pet Name: \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_  
Cell # \_\_\_\_\_

**What is the main reason for your pet's visit today?**

**Symptoms(circle all that apply)**

**Coughing   Lethargy   Sneezing   Vomiting   Diarrhea**

**If any of this Symptoms how many times a day/week, when did it start?**

**Is the problem getting better, getting worse, or about the same?**

**Has the problem been treated in any way? What treatment and did it work?**

**Do you have any other concerns about your pet's health?**

**Please list all medications your pet is currently taking (including heartworm prevention, flea control, special diet, etc)**