



**PATIENT INFORMATION**

**CANADA WEST VETERINARY SPECIALISTS AND CRITICAL CARE HOSPITAL**

1988 Kootenay Street  
Vancouver, BC V5M 4Y3

*In order for us to serve you and your pet better, please take a moment to complete this Patient Information Form.*

**PATIENT'S NAME** (First and Last name) : \_\_\_\_\_

➤ How did you acquire your pet?

Breeder          Store          Shelter          (Please provide name and location below)

\_\_\_\_\_ Date: \_\_\_\_\_

**Current Diet:**          Free choice          Set meals per day

Brand Name \_\_\_\_\_ Amount/day \_\_\_\_\_ Canned \_\_\_ Dry \_\_\_ # Meals/day \_\_\_\_\_

Brand Name \_\_\_\_\_ Amount/day \_\_\_\_\_ Canned \_\_\_ Dry \_\_\_ # Meals/day \_\_\_\_\_

Any known food allergies/intolerance? NO YES if YES please indicate known allergies or allergen testing done:

\_\_\_\_\_

**Vaccine history:** Last vaccine given \_\_\_\_\_ Date \_\_\_\_\_

**Travel History:** (Please indicate location, approximate date and length of visit)

\_\_\_\_\_

**Drug Reactions:** (Please indicate any known adverse reactions/allergies to vaccines, oral medications, anesthetics and/or topical drugs or shampoos)

\_\_\_\_\_

**Current Medication** (Please list all medications including topical medications, flea prevention and herbal/vitamin supplements)

MEDICATION	DOSAGE	FREQUENCY

**PATIENT'S NAME** (First and Last name) : \_\_\_\_\_

Do you have any other pets at home? NO YES (YES continue below, if NO go to MEDICAL HISTORY)

Has your other pet(s) been diagnosed with any types of illness recently NO YES if YES please provide info:

Current diet your other pet(s) is receiving \_\_\_\_\_

**Medical History:**

➤ Have you noticed any of the following in your pet *(please check appropriate boxes)*

Change in water intake? If YES have you noticed an INCREASE or DECREASE  
 Total water intake \_\_\_\_\_ cups/day Measured Approximate

Change in urination? If YES have you noticed any straining blood  
 Frequency \_\_\_\_\_ times per day

➤ Has your pet had any of the following *(please check appropriate boxes)*

Vomiting If YES please describe (i.e. bile/undigested food/blood) and include frequency:

\_\_\_\_\_

Diarrhea If YES have you noticed any Blood Mucous  
 Frequency and consistency: \_\_\_\_\_

➤ Has your pet exhibited any other symptoms? NO YES If YES please describe behavior changes:

\_\_\_\_\_

➤ Has your pet recently had an X-ray? NO YES If YES how long ago? \_\_\_\_\_

➤ Have you removed any ticks from your pet? NO YES If YES how long ago? \_\_\_\_\_

**Please list any previous medical problems:**

Date	Condition

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_