PLACE CLIENT/PET LABEL HERE

Neurology
PATIENT HISTORY

Date: ___________________________________ Time: ____

Presenting complaint: ____

Goals of today's visit: ____

Please check yes or no to the following questions			
		YES	**NO**
1.	Is your pet current on all vaccines?		
4.	Has your pet ever had a reaction/side effects from a medication?		
5.	Has your pet had any vomiting?		
6.	Has your pet had any diarrhea OR loose stools?		
7.	Has your pet had any coughing or sneezing?		
8.	Has your pet traveled outside of the Pacific Northwest? **(if yes, where?** ____________________)		
9.	Has your pet had any recent behavior or personality changes?		

Has your pet ever had a SEIZURE? (yes/no) __________

If yes: At what age did the first seizure occur? ______________

How frequently do the seizures occur? ____

When did the last seizure occur? ____

How long do the seizures typically last? ____

CURRENT MEDICATIONS				
	NAME of MEDICATION	DOSE	HOW OFTEN?	When was it last given?
1.)				
2.)				
3.)				
4.)				

What diet is your pet currently eating (brand, dry/canned)? ____

Please list any previous medical or surgical problems: ____

____