



**Erickson Veterinary Hospital**  
**Judith Vinson, DVM Johanna Thompson, DVM**  
**Gary Kitto, DVM Allison McGann, DVM**  
**11181 Midway, Chico, CA 95928 (530) 343-5896**

**Owner Information (please print)**

Last Name, First: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_

**\*PLEASE NOTE: cash only if no ID is provided. Thank you!**

**Pet Information:**

**Pet #1** Name: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Canine/Feline \_\_\_\_\_ Male/Female \_\_\_\_\_

Spay/Neuter \_\_\_\_\_ Birthdate: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

Previous Veterinarian/Hospital (name/address/phone): \_\_\_\_\_

**Owner's Responsibility:**

Method of Payment: (please circle one) Cash Visa/MC/Discover Debit Care Credit **(No checks)**

Credit card # (boarding/surgical services): \_\_\_\_\_ exp \_\_\_\_\_ zip \_\_\_\_\_

**Payment is required for all services at the time they are rendered** unless prior arrangements have been made with hospital management. In the event that a refund is due and the original payment is a credit card, the refund will be posted against the original credit card. We accept credit card payments over the phone with prior approval. All returned checks are subject to a \$25.00 service fee. A 90-day old account balance is subject for collection efforts and a \$25.00 collection fee will be assessed. Your signature below signifies your understanding and willingness to comply with the hospital's payment terms. In some cases, a deposit may be required before proceeding.

**Veterinary Consent:** I authorize Erickson Veterinary Hospital to perform the treatment/procedure(s) described in my pet's chart. I will be informed of the reasons for the treatment/procedure(s), along with the expected benefits and risks involved. I understand that unforeseen conditions may require an extension of a planned procedure and/or surgery. I hereby authorize the performance of such procedures or surgeries as are necessary and advisable in the professional judgment of EVH veterinarians or a relief veterinarian. I understand that I assume all risks and am responsible for all costs involved. I also authorize EVH to use pictures of my pet(s) for promotional purposes. Consent will apply to all future pets added to this account unless and until I provide a written revocation of that consent.

\_\_\_\_\_  
Signature of Owner

Owner's DOB: \_\_\_\_\_ (required for Rx)

Spouse's Name: \_\_\_\_\_

Spouse's Cell Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Spouse's Driver's license #: \_\_\_\_\_

Referred by: \_\_\_\_\_

Email address: \_\_\_\_\_

\*Owner's driver's license # \_\_\_\_\_

\*Owner's SS# \_\_\_\_\_

**Pet #2** Name: \_\_\_\_\_

Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Canine/Feline \_\_\_\_\_ Male/Female \_\_\_\_\_

Spay/Neuter \_\_\_\_\_ Birthdate: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

\_\_\_\_\_  
Date

R: 06.01.2020



## PATIENT HEALTH HISTORY FORM

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

An important part of the medical evaluation is an accurate history. Please take a few moments to complete this questionnaire. Please fill out 1 form for each pet that will be having an exam today. Do your best to answer all of the questions you can. The more information that we have, the better care we can provide for your pet. Additional information may be requested during consultation by the veterinarian.

**Patient Name:** \_\_\_\_\_ **Species:** Dog / Cat / \_\_\_\_\_ **Sex:**  M  F **Spayed/neutered?**  Yes  No

**Age:** \_\_\_\_\_ **Date of Birth** (if known): \_\_\_\_\_ **Breed:** \_\_\_\_\_ **Color/Markings** \_\_\_\_\_

**Microchipped?**  No  Yes, # \_\_\_\_\_

**What is the primary reason(s) you are seeking veterinary medical attention for your pet today?** \_\_\_\_\_

**Vaccinations:** Has your pet ever been vaccinated?  No  Yes; if yes, please provide/attach vaccine records.

Has your pet ever suffered a vaccine reaction in the past?  No  Yes (elaborate) \_\_\_\_\_

### Environment:

My pet is  exclusively indoor  exclusively outdoor  both indoor + outdoor

Are there any of the following environmental factors that your pet may be exposed to on a regular basis?

dust  cigarette/cigar-smoke/vape-pens/e-cig  foxtails  rodents/squirrels/possum/other wildlife

Do you take your pet camping/hiking/fishing/boating?  Yes  No

Are there other pets in the house?  No  Yes (describe) \_\_\_\_\_

Are there young children present in the house?  Yes  No

Has your pet previously travelled?  No  Yes (describe) \_\_\_\_\_

How long has your pet resided in the current location? \_\_\_\_\_

Previous cities/states/countries, if applicable, of residence? \_\_\_\_\_

### Flea/Tick/Heartworm/Deworming

Is your pet on flea/tick preventive?  No  Yes (brand?) \_\_\_\_\_

Is your pet on heartworm preventive?  No  Yes (brand?) \_\_\_\_\_

When was the last time your pet was dewormed?  Never  \_\_\_\_\_

Last heartworm test?  Never  \_\_\_\_\_ Was it negative?  Yes  No

For cats, has your cat ever had a leukemia/FIV test?  No  Yes, when? \_\_\_\_\_ Was it negative?  Yes  No

### Grooming

When is the last time your pet was groomed? \_\_\_\_\_

What grooming facility do you frequent (if any)? \_\_\_\_\_

How often does your pet get a bath? \_\_\_\_\_ What shampoo do you use? \_\_\_\_\_

Do you routinely clean your pet's ears?  No  Yes; if yes, when? \_\_\_\_\_

Do you routinely trim your pet's nails?  No  Yes; if yes, when? \_\_\_\_\_

### Dental

Do you brush your pet's teeth?  No  Yes; if yes, when? \_\_\_\_\_

Do you use dental products?  No  Yes; if yes, what brand? \_\_\_\_\_

Does your pet:  suffer from bad breath  drop food/drool  difficulty eating  chews on one side

**Food:**

Your pet's diet is predominately  dry food  wet/canned food  human food  combination

What brand of food? \_\_\_\_\_

What supplements/treats do you give your pet: \_\_\_\_\_

Does your pet get table scraps?  Yes  No

How often does your pet get treats  once per day  multiple times per day  weekly  monthly

Recently has your pet's appetite  decreased  increased  stayed the same

What about your pet's water consumption?  decreased  increased  stayed the same

When did your pet last eat? \_\_\_\_\_ Was it a normal amount?  No  Yes

Is there anything else we should know about your pet's diet? \_\_\_\_\_

**Medications**

Is your pet on any medications?  No  Yes; if yes please list them and the last time your pet has received a dose \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your pet have any known allergies? \_\_\_\_\_

Has your pet ever experienced an adverse event or allergic reaction to medications and/or sedation/anesthesia?  No

Yes; please elaborate \_\_\_\_\_

\_\_\_\_\_

**Labwork**

Date of last bloodwork \_\_\_\_\_  My pet has never had bloodwork done

Date of last radiograph/x-ray \_\_\_\_\_  My pet has never had a x-ray

Date of last fecal analysis \_\_\_\_\_  My pet has never had a fecal analysis

Date of last urinalysis \_\_\_\_\_  My pet has never had an urinalysis

**Last veterinary visit**

This is my pet's first visit to a veterinary hospital/facility

This hospital

Another hospital. Please write the hospital/date/doctor/diagnosis and attach medical records.

\_\_\_\_\_

**Please check any signs/symptoms you have noticed recently about your pet:**

- |   |  |
|---|--|
| <input type="checkbox"/> Bad Breath             | <input type="checkbox"/> lack of appetite  |
| <input type="checkbox"/> Behavioral Problems    | <input type="checkbox"/> limping/stiffness   |
| <input type="checkbox"/> bleeding gums          | <input type="checkbox"/> loss of balance   |
| <input type="checkbox"/> breathing problems     | <input type="checkbox"/> lumps/bumps   |
| <input type="checkbox"/> Coughing               | <input type="checkbox"/> scooting  |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> scratching, score? _____ (1 to 10, 10 being really bad)                               |
| <input type="checkbox"/> Ear Issues             | <input type="checkbox"/> seems depressed   |
| <input type="checkbox"/> Eye Discharge/Swelling | <input type="checkbox"/> seizures  |
| <input type="checkbox"/> Eyes bulging/bloodshot | <input type="checkbox"/> shaking head  |
| <input type="checkbox"/> fainting               | <input type="checkbox"/> spraying house/yard   |
| <input type="checkbox"/> fleas/ticks            | <input type="checkbox"/> sneezing  |
| <input type="checkbox"/> gagging                | <input type="checkbox"/> vomiting  |
| <input type="checkbox"/> hair loss              | <input type="checkbox"/> weakness  |
| <input type="checkbox"/> increased thirst       | <input type="checkbox"/> weight problems <input type="checkbox"/> increased <input type="checkbox"/> decreased |
| <input type="checkbox"/> increased urination    | <input type="checkbox"/> other _____   |

Has your pet ever had a history of injury, trauma, or been diagnosed with a medical illness?  No  Yes, elaborate: \_\_\_\_\_

\_\_\_\_\_

**Temperament:**

Describe your pet's normal temperament? \_\_\_\_\_

Does your pet go on car rides/trips frequently? No Yes

Do you find it difficult to get your pet into the carrier/car? No Yes, elaborate \_\_\_\_\_

How and where does your pet travel in the car? (carrier/seatbelt/loose/box/etc.) \_\_\_\_\_

During travel to the veterinary hospital, does your pet do any of the following:

- eager/excited       reluctant       hide       drool       vomit       urinate/poop  
 subdued       bark/meow       whine       pant       tremble       pace       other \_\_\_\_\_

Do you use any anxiety supplements/medications? No Yes; elaborate \_\_\_\_\_

Is your pet scared of: men    women    other dogs     other cats     uniforms     \_\_\_\_\_

My pet prefers female veterinary staff     male veterinary staff     no preference/unknown

Has your pet ever exhibited aggressive tendencies towards other pets? No Yes

Has your pet ever exhibited aggressive tendencies towards people? No Yes

How would you describe your pet around other animals and people? \_\_\_\_\_

Does your pet have any sensitive areas that s/he does not like to have touched by you or others? \_\_\_\_\_

Are there any procedures that you have been told seem difficult to perform on your pet? (nail trims, weight, temperature, ear exam, blood draw, etc.) and elaborate on how your pet reacted \_\_\_\_\_

What is your pet's favorite toy(s); if any: \_\_\_\_\_

Check any situations below that your pet has shown avoidance or dislike of in the past.

- |  |   |
|--|---|
| <input type="checkbox"/> entering the vet hospital                         | <input type="checkbox"/> going into the exam room                     |
| <input type="checkbox"/> other pets/people passing by in reception/lobby   | <input type="checkbox"/> going into the treatment area                |
| <input type="checkbox"/> waiting with other pets/people in reception/lobby | <input type="checkbox"/> sounds coming from the treatment area        |
| <input type="checkbox"/> being approached by veterinary staff              | <input type="checkbox"/> sounds of a clipper/shaver/trimmer           |
| <input type="checkbox"/> getting on the scale for a weight                 | <input type="checkbox"/> being put up on an table for examination     |
| <input type="checkbox"/> hearing the doorbell/intercom/phones ringing      | <input type="checkbox"/> direct eye contact with veterinary personnel |
| <input type="checkbox"/> loud voices during examination                    | <input type="checkbox"/> having a rectal temperature taken            |
| <input type="checkbox"/> use of a stethoscope                              | <input type="checkbox"/> use of otoscope (tool to look in ears)       |

Anything else we need to know about your pet? \_\_\_\_\_

**PAIN SCORE:** please fill out the section that is applicable for your pet (i.e., dog or cat). Ignore the numbers in ( ).

**DOGS**

A. Observation – Is your dog normally:

- Quiet (0)     crying/whimpering (1)     groaning (2)     screaming (3)

B. observe any wound or painful areas. If none, pick the first option (0)

- ignoring any wound or painful area (0)     looking at wound or painful area (1)  
 licking wound or painful area (2)     rubbing wound or painful area (3)  
 chewing wound or painful area (4)

C. When your dog walks normally, how is s/he?

- normal (0)     lame (1)     slow/reliuctant (2)     stiff (3)     refuses to move (4)

D. If it has a wound or painful area including abdomen, apply gentle pressure 2 inches around the site.

- no reaction (0)     dog looks around (1)     flinches (2)  
 growl/guard area (3)     snaps (4)     cries (5)

E. How is your dog overall?

- happy/content or bouncy (0)     quiet (1)  
 indifferent or nonresponsive to surroundings (2)     nervous/anxious/fearful (3)  
 depressed or nonresponsive to stimuli (4)

F. Overall how is your dog?

- Comfortable (0)     unsettled (1)     restless (2)     hunched/tense (3)     rigid (4)

**CATS**

A. normally:

- cat is silent / purring / meowing    0  
 Cat is crying / growling / groaning    1

B. normally:

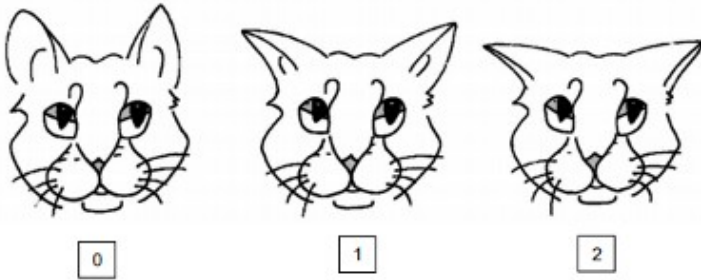
- cat is relaxed    0  
 Licking lips    1  
 Restless/cowering at back of cage    2  
 Tense/crouched    3  
 Rigid/hunched    4

C. if a wound is present:

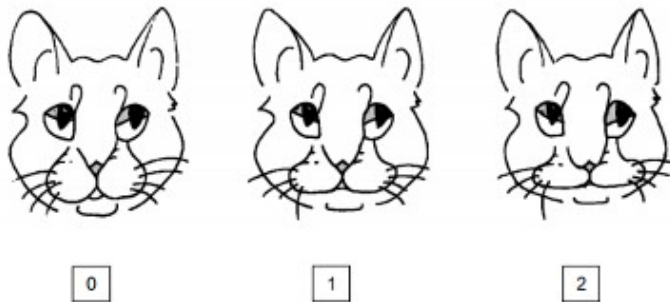
- cat is ignoring wound/painful area    0  
 Cat is paying attention to wound    1

D&E:

a) Look at the following caricatures. Circle the drawing which best depicts the cat's ear position?



b) Look at the shape of the muzzle in the following caricatures. Circle the drawing which appears most like that of the cat?



F. call cat by name & stroke along back from head to tail

- Does cat respond to stroking    0  
 Cat is unresponsive    1  
 Cat is aggressive    2

G. if cat has a wound or painful area, apply gentle pressure 5 cm around the site. In the absence of any painful area apply similar pressure around hind leg above stifle.

- Cat does nothing    0  
 Swishes tail/flattens ears    1  
 Cat cries/hisses    2  
 Growls    3  
 Bite/lash out    4

H. general impression of cat

- Happy/content    0  
 Disinterest/quiet    1  
 Anxious/fearful    2  
 Dull    3  
 Depressed/grumpy    4