

PLEASE COMPLETE AND BRING FOR WELLNESS EXAM

Date _____

Patient Name _____ **Owner Name** _____ **Acct#** _____

CANINE HISTORY AND RISK FACTOR EVALUATION

For us to evaluate your dog it is very important that you are his/her voice. We'll use this information to evaluate your dog's health and individualize the care your dog receives, including vaccinations and examinations. Please answer yes or no to the following questions to describe your dog's lifestyle.

My dog:

- Is taken for walks. () Yes () No
- Is taken to parks for exercise and play () Yes () No
- Goes camping with us () Yes () No
- Is taken to groomers () Yes () No
- Occasionally goes to Petsmart or PetCo () Yes () No
- Is taken to the country or farm () Yes () No
- Is taken to boarding kennels when we are on vacation () Yes () No
- Is taken to outdoor community events () Yes () No
- Is taken to community vaccination clinics () Yes () No
- Is sometimes visited or visits other dogs () Yes () No
- Attends obedience or training classes () Yes () No
- Participates in competitive events, i.e. dog shows () Yes () No
- Is used for hunting () Yes () No
- Is kept in a yard with an electric fence () Yes () No

Please answer the following questions to the best of your knowledge.

- Appetite () Decreased () Increased () Normal
- Weight () Loss () Gain () Stable
- Water Consumption () Decreased () Increased () Normal
- Bowel Movements () Constipated () Normal () Diarrhea
- Urination () Decreased () Normal () Increased Frequency/Amount
- Incontinence (Loss of Housetraining) () Yes () No
- Vomiting () Yes () No
- Coughing () Yes () No
- Sneezing () Yes () No
- Gagging () Yes () No
- Listlessness () Yes () No
- Weakness () Yes () No
- Shaking Head () Yes () No
- Scratching () Yes () No Location _____
- Significant Hair Loss () Yes () No
- Flea Control Used () Frontline () Advantage () Revolution () Other
- Heartworm Control () Heartgard () Sentinel () Interceptor () Other
- Scotting () Yes () No
- Unusual Lumps/Bumps () Yes () No
- Bad Breath () Yes () No
- Unusual discharge () Yes () No Location _____
- Lameness () Yes () No Which Leg () RF () LF () RR () LR
- Difficulty Rising () Yes () No
- Behavioral Changes () Yes () No
- Allergies/Reactions to Medication or Vaccination () Yes () No
- Current Medications _____