PATIENT REGISTRATION FORM

TIME ARRIVED: _____

WEIGHT: _____

CASE NO: _____

DATE: _____

YOUR NAME: _____ CO-OWNER: _____
(LAST) (FIRST) (INITIAL) (LAST) (FIRST) (INITIAL)

ADDRESS: _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

PHONE: _____ FAX: _____

CELLULAR: _____ E-MAIL: _____

Who referred you to us? _____

If not your regular veterinarian, please list
name of regular veterinarian and clinic: _____

EMPLOYER: SELF: _____ PHONE: _____

SPOUSE: _____ PHONE: _____

PET'S NAME: _____ IS YOUR PET A: DOG _____; CAT _____; OTHER _____

BREED: _____ COLOR: _____ SEX: M F

DOB: ____/____/____ AGE: _____

LAST DISTEMPER VACCINATION DATE: _____; RABIES DATE: _____

HAS YOU PET BEEN NEUTERED OR SPAYED: YES NO

REASON FOR VISIT: _____

_____

_____

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_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME: OWNER: _____ PET: _____ CASE NO. _____

DATE: _____

A complete background and thorough history are essential to help obtain an accurate diagnosis of your pet's illness. Please fill out this questionnaire as completely as possible.

How long have you owned your pet? _____

Where was your pet obtained? (Breeder; Humane Society; Private Party; Friend, etc.) _____

Has your pet traveled out of state in the past 2 years? yes no unknown

If yes, where? _____

Has your pet ever had ticks? yes no unknown

If yes, when? _____

Is your pet kept primarily outdoors or in the house? _____

Are there any other pets in your household? yes no

If yes, what? _____

What is your pet's diet? _____

Is your pet ever fed table food? yes no

How much and how often does your pet eat? _____

Has your pet been boarded or hospitalized recently? yes no unknown

Has your pet been treated for any major medical problems? yes no unknown

If yes, what and when? _____

Has any bloodwork been done within the past 12 months? yes no unknown

If yes, was *Valley Fever* tested for? yes no unknown

If yes, was *Tick Fever* tested for? yes no unknown

Have any x-rays been taken within the past 12 months? yes no unknown

If your pet's been neutered/spayed, what was his/her age of alteration? _____

If female and not spayed, when was her last heat? _____

If female, has she had any litters? yes no unknown

If yes, when? _____

Has there been a change in your pet's appetite? yes no unknown

If yes, is it *increased* or *decreased.* (circle one)

Has there been a change in your pet's water consumption? yes no unknown

If yes, is it *increased* or *decreased.* (circle one)

Is your pet urinating more frequently than normal? yes no unknown

Has your pet been straining to urinate? yes no unknown

Have you noticed your pet vomiting? yes no unknown

If yes, what is the frequency? _____

CASE NO. .....

Has there been a change in your pet's bowel movments? yes no unknown

If yes, describe the appearance (color and consistency). .....

.....

What is the frequency of defecation? .....

Has there been any straining to defecate? yes no unknown

Have you seen blood in any urine, vomitus, or stool? yes no unknown

Has your pet been scratching? yes no unknown

Has your pet had any seizures or convulsions? yes no unknown

Has there been a change in your pet's attitude or behavior? yes no unknown

If yes, describe. .....

.....

Has there been any change in your pet's walking? yes no unknown

Has your pet lost any stamina lately? yes no unknown

Have you noticed any abnormal swellings? yes no unknown

If yes, where? .....

Have you noticed any abnormal discharges or drainage? yes no unknown

If yes, describe (eyes, nose, vulva; appearance). .....

.....

Has your pet had difficulty breathing? yes no unknown

Has your pet had any coughing? yes no unknown

If yes, circle the most appropriate description below.

The frequency is *occasional, frequent,* or *continuous.*

It occurs most often at *night, morning, exercise, excitement,* or *anytime.*

Would you describe the cough as *mild, moderate,* or *severe?*

Has your pet had any unexpected reactions to medications? yes no unknown

Has your pet received aspirin during the past 6 months? yes no unknown

Is your pet currently receiving medications? yes no unknown

If yes, give name and dosage (if known). .....

.....

Describe your primary concern(s) about your pet. .....

.....

.....

.....

When did this problem(s) begin? .....

.....

Please make additional comments on the reverse side of this page.

Case No _____

Veterinary Neurological Center
Pre-MRI Questionnaire

Today's Date _____

Patient _____ Owner _____

Breed _____

Age _____

Sex _____ Circle one: (neutered / spayed)

Please circle any of the following items that your pet may have:

Identification Microchip

Metal Dental Work (e.g. crowns)

Pacemaker

Orthopedic Implants (e.g. pins, plates)

Birdshot

Stainless Steel Sutures

Surgical Staples

Other:

To my knowledge, my pet has no metal implants other than those noted above:

_____ _____

Signature (Owner/Agent) Date