VETERINARY NEUROLOGICAL CENTER

Patient Registration Form

Arrival Time: _____
Weight: _____
Case No: _____
Date: _____

Your Name: _____ **Co-Owner**: _____
(last) (first) (initial) (last) (first) (initial)

Address: _____
(Number) (Street) (City) (State) (Zip Code)

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 your pet been neutered or spayed?: YES NO

Reason for visit: _____

_____

_____

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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, Human Society, Private Party, Friend, Etc.) _____

Has your pet travelled 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? _____

Does your pet have any known food or other allergies? yes no unknown

If yes, what is your pet allergic to? _____

Does your pet have any allergies or had adverse reactions to any medications? yes no unknown

If yes, which medications? _____

Has your pet been hospitalized recently? yes no unknown

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

If yes, what and when? _____

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

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

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

If female and not spayed, has she had any litters? yes no unknown

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

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Case No. _____

Have you noticed your pet vomiting? yes no unknown

If yes, what is the frequency? _____

Has there been a change in your pet's bowel movements? 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 received any aspirin in the past 6 months? yes no unknown

Is your pet currently receiving any medications? yes no unknown

If yes, give the name(s) and dosage(s) (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.

VETERINARY NEUROLOGICAL CENTER

CASE NO. _____

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 implants or metallic devices in his/her body other than those listed above:

_____ _____

Signature (Owner/Agent) **Date**