

# Pet Health History Form

*Note:* Required fields are marked with an asterisk (\*)

Please fill out a Pet health History form for each patient Dr Rubsch is visiting or will be visiting in the future to put in your medical records.

Owner Info \_\_\_\_\_

Owner Name \_\_\_\_\_

Email Address \_\_\_\_\_

\*We will never sell or disclose your email address to anyone.

Pet History

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Pet Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Type of Animal   Dog            Cat            Other

Sex

Male Neutered                      Female Spayed

Breed \_\_\_\_\_

Color \_\_\_\_\_

Weight \_\_\_\_\_

Vaccinations:

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Please check any symptoms or problems you have noticed about your pet.

Bad Breath

Behavioral Problems

Bleeding Gums

Breathing Problems

Coughing

Diarrhea

Eyes Bulging or Bloodshot

Gagging

Lack of Appetite

Limping

Loss of Balance

Scotting

Scratching

Seems Depressed

Shaking Head

Sneezing

Thirst and/or Urination Increased

Vomiting

Weakness

Weight Problem

Other Problem

Current Medications

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Describe your pet's diet in detail, including any and all treats:

Consent

By submitting this form, I understand that I am authorizing the Veterinarian to examine, prescribe for or treat the above described pet. I assume full responsibility for all charges incurred in the care of this animal. I understand that charges must be paid at time of service.

**I agree**