

**PVSEC – Internal Medicine**

**NEW PATIENT HISTORY SHEET**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Neutered/Spayed: Y N

Species: Feline Canine Breed: \_\_\_\_\_

If feline: Indoor Outdoor Indoor & Outdoor

What is your pet's current problem: \_\_\_\_\_

\_\_\_\_\_

Do you have any other pets at home? (If yes, what are they?) \_\_\_\_\_

What do you currently feed your pet? \_\_\_\_\_

When was your pet last vaccinated? \_\_\_\_\_

Are you using any flea/tick/heartworm preventive? (please list) \_\_\_\_\_

Has your cat been tested for feline leukemia and/or FIV? (if yes, when and results:) \_\_\_\_\_

Has your dog been tested for heartworm and/or lyme disease? (if yes, when and results:) \_\_\_\_\_

Please list any previous health problems, surgeries or allergies we should know about:

\_\_\_\_\_

Please list current medications (including over-the-counter), when started, dosage and response: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Staff use only: T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

wt \_\_\_\_\_ CRT \_\_\_\_\_ mm \_\_\_\_\_

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**PLEASE TURN OVER -->**

Has your pet exhibited any of the following? (Please circle all that apply)

Lethargy	Yes	No		
Drinking an abnormal volume	Yes	No		
Frequent or difficult urination	Yes	No		
Urinating an abnormal volume	Yes	No		
Changes in appetite	Yes	No		
Vomiting	Yes	No		
Diarrhea	Yes	No		
If yes, please circle all that apply	Blood	Clear Mucous	Straining	Black stool
Constipation / difficulty defecating	Yes	No		
Recent weight loss	Yes	No		
Coughing	Yes	No		
Sneezing	Yes	No		
Abnormal Breathing	Yes	No		
Gagging / retching	Yes	No		

For each "Yes" circled above, please describe and not frequency, duration, progression, response to treatment, and/or any other information:

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Does your pet have any other problems we should know about?

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Thank you for bringing your pet to PVSEC – Internal Medicine.



Pittsburgh Veterinary Specialty and Emergency Center  
Internal Medicine  
412-366-3400