



CLIENT INFORMATION

Last Name _____ First Name _____

Additional Owner, Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Please indicate your preferred method of contact: Home Phone Cell Phone Work Phone Email Text US Mail

How did you hear about us? _____

Current University of Illinois faculty, staff, or student? Yes No

PET INFORMATION

Pet's Name _____

M F Dog Cat

Is your pet indoor, outdoor or both? (please circle)

Breed _____ Color _____

Age or Date of Birth _____ Neutered, at age _____

Microchip Number _____

Primary Reason for Today's Visit

Please check any symptoms or problems you've noticed with your pet:

- | | | |
|---|--|---|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Gums Bleeding | <input type="checkbox"/> Thirst Increase |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Urination Decrease |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Urination Increase |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Eye Disorders | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Weight Gain/Loss |

Other _____

Other _____

I think my pet is (choose one) underweight / ideal weight / overweight.

Are you concerned about your pet's weight? (choose one) yes / no

Vaccine, Test and Pet Health History

Bordetella Y N Unsure Date _____

Dental Y N Unsure Date _____

Distemper Y N Unsure Date _____

Feline Leukemia Test Y N Unsure Date _____

FVRCP (Cat Disease) Y N Unsure Date _____

Leptospirosis Y N Unsure Date _____

Lyme Y N Unsure Date _____

Parvovirus (Dog) Y N Unsure Date _____

Rabies (Dog/Cat) Y N Unsure Date _____

Heartworm Test Y N Unsure Date _____

Heartworm Preventive Y N Type _____

Prior Surgery _____

Prior Illness _____

Previous Labwork _____

Other _____

Please describe your pet's diet _____

Please list all your pet's medication(s) _____

Please list any allergies _____

Is there anything else in specific we should know about your pet?

SECOND PET INFORMATION

Pet's Name _____

M F Dog Cat

Is your pet indoor, outdoor or both? (please circle)

Breed _____ Color _____

Age or Date of Birth _____ Neutered, at age _____

Microchip Number _____

Primary Reason for Today's Visit

Please check any symptoms or problems you've noticed with your pet:

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| <input type="checkbox"/> Behavioral Changes | <input type="checkbox"/> Gums Bleeding | <input type="checkbox"/> Thirst Increase |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Urination Decrease |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Urination Increase |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |
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Feline Leukemia Test Y N Unsure Date _____

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Rabies (Dog/Cat) Y N Unsure Date _____

Heartworm Test Y N Unsure Date _____

Heartworm Preventive Y N Type _____

Prior Surgery _____

Prior Illness _____

Previous Labwork _____

Other _____

Please describe your pet's diet _____

Please list all your pet's medication(s) _____

Please list any allergies _____

Is there anything else in specific we should know about your pet?

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet(s). I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature _____ Date _____

I hereby grant full permission to Medical District Veterinary Clinic at Illinois and/or the University of Illinois to utilize photograph(s) or images of the above described pet(s) in any publication or advertising materials (printed or electronic) for educational or marketing purposes. This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my pet's photograph and/or name.

Signature _____ Date _____