



PATIENT HISTORY FORM

Client Name: _____

Mailing address: _____

Email address: _____

Pet's Name: _____ Pet's Date of Birth: _____

Pet's Breed: _____ Has your pet been spayed or neutered? _____

1. Why is your pet seeing CACC today?

2. What other health problems has your pet been diagnosed with?

3. What medications or supplements is your pet currently taking (please include the strength of any tablet and how often you are giving it to your pet)?

4. Is your pet drinking (check box that applies):

- A normal amount of water
- Less water than normal
- More water than normal

5. Is your pet urinating (check box that applies):

- A normal amount
- Less often than normal
- More often than normal

6. If your pet is **coughing**, please answer the following (check box if yes/leave blank if no):

A. Does the cough sound:

- Dry
- Wet
- Honking

B. Do any of the following set off the cough?

- Excitement
- Eating
- Drinking
- Other : _____

C. Does the cough wake your pet up at night? Yes No

D. Does the cough occur spontaneously throughout the day? Yes No

7. Have you noticed any unexplained limping or dragging of any limbs? If so, please describe:

8. If your pet has had a **fainting episode** or episodes please answer the following questions:

A. How many fainting episodes have you witnessed your pet have: _____

B. Which of the following best describe your pet just prior to the episode(s):

- Exercising or very excited (running/playing/greeting at the door/etc.)
- Urinating or defecating
- Coughing
- Sleeping or resting & just got up to move around
- Other: _____

C. During the episode does your pet do any of the following (check all that apply):

- Lose consciousness
- Lose bladder control
- Lose bowel control
- Limbs become limp
- Limbs become rigid and may paddle
- Salivate excessively
- Clench the jaw
- Other: _____

D. How long does each episode last: _____

E. How long does it take for your pet return to normal after an episode? _____

9. Please help us understand how your pet is currently doing at home by identifying which of the following clinical signs you have noticed at home and to what extent they seem to be affecting your pet on a daily basis. Circle the number that most appropriately describes how often you appreciate each symptom at home: 0= Never, 1= Rarely, 2=Occasionally, 3= Frequently, 4= All the time.

Coughing	0	1	2	3	4
Lethargy	0	1	2	3	4
Exercise Intolerance	0	1	2	3	4
Fainting spells	0	1	2	3	4
Labored breathing	0	1	2	3	4
Decreased appetite	0	1	2	3	4

10. Are there any other symptoms or concerns you would like us to be aware of?

11. What phone number can we reach you at today? _____

*We respectfully request that you keep your phone nearby so we are able to discuss the results of your pet's testing with you directly.

*Anxiety and nervousness can interfere with our ability to perform and interpret cardiac tests. Heart-friendly sedatives may be needed to complete the examination and work-up if your pet is too nervous to stay still and remain calm during the required tests.

* Please provide advance notice to your veterinarian if you cannot keep your appointment! If you fail to appear for your appointment or cancel after we are already en route to your veterinarian's office it will result in a **\$125 cancellation fee** to cover the cost of lost time and travel.