

Four Winds Holistic Animal Services Patient Medical History

Owner Contact Information

Owner Name _____ Date ____/____/____

Animal name _____ Age/DOB _____

Provide all phone numbers where we can contact you today.

Cell phone (____) ____-____ Home phone (____) ____-____

Work phone (____) ____-____ Spouse's cell (____) ____-____

Patient Information

Canine _____ Feline _____

Male _____ Intact _____ Neutered _____ Unkown _____

Female _____ Intact _____) Spayed _____ Unkown _____

Vaccination History

Rabies Date _____ 3 year or 1 year Circle one

Distemper/Parvo Date _____

Other _____ Date _____

Medical History

Is your animal on natural or chemical heartworm prevention? YES or NO

Date last given_ ____/____/____

Name of heartworm prevention given _____

Is your animal on natural or chemical flea and/or tick prevention. YES or NO

Date last given_ ____/____/____

Name of flea/tick prevention given _____

Four Winds Holistic Animal Services Patient Medical History

Does your animal have known allergies to food, medication, supplements, or vaccines? YES or NO

If yes, list known allergies here _____

If vaccine reaction, please indicate date and name of vaccine _____

Please list all prescription medications your animal is on

Medicine _____ Dose _____ Time AM__ Noon__ PM__

Medicine _____ Dose _____ Time AM__ Noon__ PM__

Medicine _____ Dose _____ Time AM__ Noon__ PM__

Medicine _____ Dose _____ Time AM__ Noon__ PM__

Please list all over the counter medications your animal is on

Medicine _____ Dose _____ Time AM__ Noon__ PM__

Medicine _____ Dose _____ Time AM__ Noon__ PM__

Medicine _____ Dose _____ Time AM__ Noon__ PM__

Please list all natural treatments (supplements, herbs, homeopathy, etc) your animal is on

Name _____ Dose _____ Time AM__ Noon__ PM__

Name _____ Dose _____ Time AM__ Noon__ PM__

Name _____ -Dose _____ Time AM__ Noon__ PM__

Name _____ Dose _____ Time AM__ Noon__ PM__

Name _____ -Dose _____ Time AM__ Noon__ PM__

Please list energetic treatments (e.g. Assisi loop) your animal is receiving

Name _____ How often _____

Four Winds Holistic Animal Services Patient Medical History

Please list any additional medications or natural treatments using this format on a separate sheet of paper and attach.

Diet

Normal Diet (brand) _____

Total cups _____ Cans _____ Patties _____ per day _____

If your animal eats a home made diet, please attach recipe.

Water (Circle). Tap Spring Filtered(filter name _____) Distilled

Release for treatment: I the undersigned do certify that I am the owner, or authorized agent of the owner of this animal; that I hereby authorize Four Winds Holistic Animal Services,, their agents and representatives, after consultation with me, to perform medical procedures, physical examinations, anesthesia, x-ray, administer drugs, or other such treatment(s) as the veterinarian deems necessary. I agree to accept responsibility for the payment of all services rendered. Payment is due at the conclusion of the appointment. I authorize Four Winds Holistic Animal Services to release the medical records of my pet(s) in good faith and without additional consent.

Signed _____ Date ____/____/____