

Capital Area Veterinary Specialists
Texas Veterinary Oncology
7958 Shoal Creek Blvd
Austin, Tx 78757
512-388-0944

Date: _____

Client Name: _____

Patient Name: _____

Phone Number: _____

Check In History

Reason for Visit: _____

History

Any **past surgeries?** _____

Any **past illnesses/diseases?** _____

Medications

Is your pet **allergic** to any medications that you are aware of? _____

Any **medications currently** taking and dosages:

1. _____

2. _____

3. _____

Observations

- Any **coughing or sneezing?**
- Any **vomiting or diarrhea?**
- Any **change in appetite?**
- Any **increased thirst or urination?**
- Any **observed lumps / bumps?**
- Any **observed scratching / licking?**
- Any **observed soreness or stiffness** after resting or exercise?
- Any observed **change in weight?**
- Any observed **behavior changes?**

Diet

What diet food are you feeding?
How much? _____ cup/s Frequency 1X 2X 3X

Any Additional Comments/Concerns